HIAA

A5173-2U

Health Insurance Association of America

SOURCE BOOK OF HEALTH INSURANCE DATA

1990

HIAA

SOURCE BOOK OF HEALTH INSURANCE DATA

1990

CONTENTS

TABLES .... *v*

PREFACE .... *ix*

THE ROLE AND FUNCTION OF HEALTH INSURANCE 1
The Beginnings of Modern Health Insurance 1
Medicare and Medicaid 3
Recent Changes 3
The Increasing Visibility of Managed Care 4
Major Trends in Coverage, Utilization and Expenditure 5

THE PRIVATE HEALTH INSURANCE INDUSTRY 9
Coverage 9
Types of Private Health Insurance 10
  Hospital/Medical Insurance 10
  Major Medical Expense Insurance 11
  Disability Income Protection (Loss of Income) 11
  Dental Expense Insurance 11
  Long-Term Care Insurance 12
  Group Self-Insurance 12
Employers Offering Health Insurance 13
The Population without Health Care Coverage 13
  A Continuing Problem 14
Health Insurance Claims 14
Health Insurance Premiums 15
  Group and Individual Premiums 16
  Insurance Premiums Paid by Employers 18
The Evolution of Managed Care 18
  A Definition of Managed Care 19
  History of Managed Care 19
  Current Trends 21
  Outlook for the Future 22

PUBLIC HEALTH CARE COVERAGE—EXPENDITURES AND ENROLLMENT 35
Federal, State and Local Health Care Programs 35
Federal Programs 35
  Medicare 36
  Medicaid 37
  Utilization of Medicare and Medicaid Services 37

Other Government Services 37
  Military Personnel and Dependents 37
  Federal Civilian Employees 38
  Veterans Medical Care 38
  Indian Health Services 38
State and Local Programs 38

MEDICAL CARE COSTS 47
National Health Expenditures (NHE) 47
  Personal Health Care Expenditures 47
  Consumer Price Index 50
  Hospital Statistics 51
  Professional Fees 52
The Cost of Mental Illness and Drug Abuse 53
The Cost of Having a Baby 53
Medical Costs Resulting from Accidents 54
International Health Care Expenditures 54

HEALTH SERVICES, RESOURCES AND UTILIZATION 75
Utilization by Diagnosis 75
Physician Visits 76
Hospital Facilities and Numbers of Physicians 76
Organ Transplants 77

DISABILITY, MORBIDITY AND MORTALITY 87
Disability 87
  Occupational Illnesses and Injuries 87
  Acute Conditions 88
  Chronic Conditions 88
Social Security Disability Insurance Program 89
Morbidity and Mortality 89

HEALTH AND HEALTH CARE ACRONYMS 101

HISTORICAL INSURANCE FACTS 103

GLOSSARY 111

INDEX 125

TABLES

CHAPTER 1

Table 1.1 .... Key Health Insurance Statistics

CHAPTER 2

Table 2.1 .... Health Care Coverage in the United States in Selected Years (Millions)
Table 2.2 .... Number of Persons with Private Insurance Protection by Type of Insurer (Millions)
Table 2.3 .... Health Insurance Coverage by Age and Race (1986–1988) (Percent)
Table 2.4 .... Percent of Firms Offering Health Coverage by Associated Industry
Table 2.5 .... The Relationship of Wages to Providing Health Benefits
Table 2.6 .... Private Health Insurance Claims Payments by Type of Insurer (Billions)
Table 2.7 .... Group Health Claims Payments of Insurance Companies by Type of Coverage (Billions)
Table 2.8 .... Group Health Claims Payments of Insurance Companies by Type of Risk Management (Billions)
Table 2.9 .... Individual Health Insurance Claims Payments of Insurance Companies by Type of Coverage (Billions)
Table 2.10 .... Health Insurance Premiums of Insurance Companies, Self-Insured and HMO Plans and Blue Cross-Blue Shield
Table 2.11 .... Group Health Insurance Premiums of Insurance Companies by Type of Coverage (Billions)
Table 2.12 .... Group Health Insurance Premiums of Insurance Companies by Type of Risk Management (Billions)
Table 2.13 .... Individual Health Insurance Premiums of Insurance Companies by Type of Coverage (Billions)
Table 2.14 .... Underwriting Results for Insurance Companies and Blue Cross-Blue Shield (1984–1988)
Table 2.15 .... HMO Enrollment and Percent of Population in HMOs by State (1989)
Table 2.16 .... Number of HMOs and HMO Enrollment by Selected Characteristics (1989)
Table 2.17 .... Percent of Health Plans Providing Coverage for Specific Services by Plan Type (1988–1989)
Table 2.18 .... Operational PPOs by State and Selected Regions (1987–1989)

CHAPTER 3

Table 3.1 .... Medicare Enrollments and Payments (Millions)
Table 3.2 .... Medicaid Recipients and Benefits Paid by Federal and State Governments (Millions)
Table 3.3 .... Medicare and Medicaid Benefits, Medicare Enrollments and Medicaid Recipients by State and Territory (1988) (Millions of dollars, thousands of persons)
Table 3.4 .... Hospital and Medical Expenditures under Worker's Compensation (Millions)
Table 3.5 .... Expenditures of State Health Agencies and Local Health Departments by Program Area (1988)

CHAPTER 4

Table 4.1 .... National Health Expenditures by Type of Expenditure and Source of Funds (1987–1988) (Billions)
Table 4.2 .... National Health Expenditures in Aggregrate, Per Capita, Percent Distribution and Percent Change by Source of Funds (1960–1988)
Table 4.3 .... National Health Expenditures and Gross National Product (1950–1988)
Table 4.4 .... Personal Health Care Expenditures by Source of Payment (1960–1988)
Table 4.5 .... Personal Consumption Expenditures by Type of Expenditure (1985–1988) (Billions)
Table 4.6 .... Personal Consumption Expenditures for Medical Care by Type of Service (1950–1988) (Billions)
Table 4.7 .... Personal Consumption Expenditures for Medical Care as Percent of Disposable Personal Income and as Percent of Total Personal Consumption Expenditures (1950–1989) (Billions)
Table 4.8 .... Annual Percent Change in Consumer Price Index (All Urban Consumers) (1969–1989)
Table 4.9 .... Community Hospital Statistics by State (1988)
Table 4.10 .... Percent Change in Selected Components of Consumer Prices, Urban Consumers (1980–1989)
Table 4.11 .... Hospital Semiprivate Room Charges by State and Territory (1987–1990)
Table 4.12 .... Median Physicians' Fees for Surgical Procedures by Specialty (1989)
Table 4.13 .... Median Physicians' Fees for Office Visits by Region by Specialty (1989)
Table 4.14 .... Cost of Maternity Care, Physicians' Fees and Hospital Charges by Census Region (Weighted Averages)

Table 4.15 .... Mental Disorders by Age, Sex, Race and Region (1988) (Thousands)
Table 4.16 .... Visits and Charges for Psychotherapy by State (1988–1989)
Table 4.17 .... Cost of High-Technology Medical Procedures (1989)
Table 4.18 .... Surgical Procedure Utilization and Average Charge Per Procedure (Mutual of Omaha Insurance Company) (1988–1989)
Table 4.19 .... Cost of Accidents by Class (Billions)

CHAPTER 5

Table 5.1 .... Community Hospital Statistics (1950–1988)
Table 5.2 .... Number and Rate of Patients Discharged from Short-Stay Hospitals, Days of Care, Average Lengths of Stay by Sex and Age (1988)
Table 5.3 .... Patients Discharged from Short-Stay Hospitals by Category of First-Listed Diagnosis by Sex and Age (1988) (Thousands)
Table 5.4 .... Procedures Provided to Patients Discharged from Short-Stay Hospitals by Category, Sex and Age (1988) (Thousands)
Table 5.5 .... Average Number of Patient Visits Per Week by Physician Specialty and Census Division (1982–1988)
Table 5.6 .... Percent of Community Hospitals with Selected Special Facilities, Services and Special Beds (1980–1988)
Table 5.7 .... Length of Stay for Selected Disease Categories in Selected Countries (Days)
Table 5.8 .... Estimates and Projections of Active Physicians and Dentists (1950–2000) (Thousands)
Table 5.9 .... Community Hospitals, Beds, Admissions and Occupancy (1972–1988)
Table 5.10 .... Organ Transplants in the United States (1988–1989)

CHAPTER 6

Table 6.1 .... Probability of Disability or Dying between Age 20 and Attained Age for Workers Eligible for Social Security Income (1986)
Table 6.2 .... Disability Days Due to Acute Conditions by Social and Economic Characteristics (1987–1988)
Table 6.3 .... Workdays Lost Due to Acute Conditions (1987–1988)
Table 6.4 .... Number of Occupational Injuries and Illnesses and Lost Workdays, Private Sector by Industry Division (1987–1988) (Thousands)
Table 6.5 .... Occupational Injury and Illness Incidence Rates Per 100 Full-Time Employees

Table 6.6 .... Growth in the Social Security Disability Program (1965–1988)
Table 6.7 .... Life Expectancy at Birth and at 65 Years of Age
Table 6.8 .... AIDS Cases by Cases and Deaths before 1981 through December 1989
Table 6.9 .... The 10 Most Common Causes of Death (1987)
Table 6.10 .... Death Rates for the Four Leading Causes of Death by State (1987) (Per 100,000 residents)
Table 6.11 .... Trends in Death Rates (1920–1987)

PREFACE

The 1990 edition of the *Source Book of Health Insurance Data* is the thirtieth consecutive edition of this report, which has been published annually by HIAA since 1960.

A statistical report of private health insurance in the United States, the *Source Book* is compiled by HIAA's Policy Development and Research Department. The report provides the latest available data on the major forms of health insurance coverage, medical care costs, utilization of the nation's medical facilities and national morbidity trends. It also contains new and updated information on health care and health care fields, incorporating new facts about managed health care. Expanded sections on medical care costs and utilization data also have been added.

The data found in the *Source Book* are taken from reports of insurance companies, government agencies, hospital and medical associations and other health insurance plans.

The *Source Book* is meant to be a basic reference tool for writers, editors, researchers, educators, government leaders, hospital and medical professionals, members of business associations and others interested in the health care industry.

HIAA hopes that this thirtieth edition proves as valuable as its predecessors.

Many people contributed to this document, in particular Al Minor, HIAA's Consumer Studies Coordinator, who was the *Source Book's* project manager.

Richard E. Curtis
Director, Policy Development and Research Department

Chapter 1

THE ROLE AND FUNCTION OF HEALTH INSURANCE

Health insurance provides people with a way to protect themselves against financial catastrophe and to assure themselves and their families of access to the health care system.

In 1850, The Accidental Death Association of London was the first company to offer coverage for medical expense for bodily injuries that did not result in death. In the United States at the end of that same year, the Franklin Health Assurance Company of Massachusetts offered the same type coverage. Ten years later, The Travelers Insurance Company of Hartford began offering medical expense coverage on a basis resembling health insurance in its present form. By 1866, health insurance policies were being written by 60 other insurance companies.

At the beginning of the twentieth century, both accident insurance companies and life insurance companies were writing health insurance policies. The early policies were essentially loss-of-income policies and provided benefits for a limited number of diseases such as typhus, typhoid, scarlet fever, smallpox, diphtheria and diabetes.

◆ The Beginnings of Modern Health Insurance

The birth of modern health insurance came in 1929, when a group of school teachers made a contract with Baylor Hospital in Dallas, Texas, to provide room, board and specified ancillary services at a predetermined monthly cost. This plan generally is acknowledged as the first of what came to be called Blue Cross plans. The Blue Cross plans were attractive not only to consumers but also to hospitals because they needed to find a mechanism to assure that patients would be able to pay for services they provided. For patients who were covered by the Blue Cross plan, payment was made directly from the plan to the hospital, rather than reimbursing the patient, who would then pay the hospital. Coverage under the Blue Cross policies was typically for a hospital stay of a specified number of days or for particular hospital services. These plans contrasted with the indemnity plans offered by private insurance carriers which provided reimbursement to (that is, "indemnified") the patient for covered services up to a specified dollar limit. It was up to the hospital to collect the money from the patient. Blue Shield plans, initiated by physicians, followed and were based on similar concepts except they offered coverage for physician services. The Blue Cross and Blue Shield plans traditionally established premiums by "community rating," that is, everybody in the community paid the same premium.

Starting in the 1930s and continuing into the war years, traditional insurance companies began to add health insurance coverage for hospital, surgical and medical expenses to their accident and life insurance lines of business. During World War II, group health insurance became an attractive benefit to workers at a time when wages were frozen. The trend was strengthened by the favorable tax treatment that fringe benefits received. Unlike money wages, they were not subject to income or Social Security taxes, so a dollar of health insurance was worth more than an after-tax dollar spent out of pocket for medical services. Health insurance quickly became a benefit that was covered by the collective bargaining contracts of employee groups. Its position as a permanent part of employee benefits was assured in the postwar era when the Supreme Court ruled that employee benefits, including health insurance, were a legitimate part of the labor-management bargaining process.

Although early policies were often sufficiently broad to cover the expenses of common accidents and illnesses, they were inadequate to cover extended illnesses or long hospital stays. To correct this deficiency, in the early 1950s insurers began to offer major medical expense insurance to cover catastrophic cases. Soon thereafter, Blue Cross-Blue Shield followed the lead of the private insurers and offered similar plans. Typically the policyholder under major medical expense insurance paid a specified deductible amount after which the insured and the insurer shared the covered losses according to a specified ratio (coinsurance).

During the 1950s, health insurance protection expanded rapidly and by the middle of the decade 77 million people had hospital expense insurance in either the indemnity form or the major medical plan.

In the next few years, insurance companies began to offer a new high-benefit major medical plan, which encompassed "out-of-pocket" cut-off points beyond which the insurance company paid 100 percent of covered expenses.

These same types of health insurance plans, expanded in coverage to meet new medical technology, are in wide use today.

◆ Medicare and Medicaid

During the next 20 years, health insurance would not only continue to cover an increasing number of people, but greatly broaden the scope of its coverage. The federal government's Medicare program for people over the age of 65 became effective July 1, 1966.

For the portion of the working population covered by Social Security, it provided compulsory hospitalization insurance (Part A) as well as voluntary supplementary medical insurance (Part B) to help pay for physicians' services, medical services and supplies not covered by the hospitalization plan. To fill gaps in Medicare coverage, nearly 23 million or 70 percent of Medicare enrollees supplement their Medicare benefits with private insurance policies.

Medicaid, designed to share the cost of medical care for low-income people, also became effective in 1966 under Title 19 of the Social Security Act. It allowed states to add health coverage, with federal matching funds, to their public assistance programs for low-income groups, families with dependent children, the aged and the disabled. Because eligibility is based upon meeting a number of criteria other than low income, only 40 percent of the below-poverty population is covered by the Medicaid program today.

◆ Recent Changes

Traditionally, private insurance companies determined premiums through actuarial assessments of the risk associated with the insured group, and premiums would differ from group to group because the risk of groups varied. In other words, groups' premiums were based on their own medical claims experience, later known as experience rating. It was only a short step from experience rating to self-insurance. Some big companies realized that their work force was large enough that aggregate medical experience and expenses of their employees would vary little from year to year (except for inflation in medical prices). Given such predictability of medical experience and expense, it was feasible for large companies to self-insure. Rather than pay insurers a premium to bear the risk, the employer could simply assume the risk by budgeting a certain amount to pay claims. In addition, the firm could retain control over funds until the time a medical bill needed to be paid.

The incentives for firms to self-insure were strengthened by two other factors related to government regulations. In virtually all states, insurance companies had to pay a premium tax of several percentage points, the cost of which was passed on to customers. Self-insured firms could avoid this cost. In addition, states began to mandate that insurance policies cover certain specified services and the services of particular provider groups. But the Employee Retirement

Income Security Act of 1974 (ERISA) prohibited states from applying these mandates to self-insured plans. Thus employers who did not want to pay the extra costs of these mandated benefits (now exceeding 700 when aggregated across all states) could avoid doing so by self-insuring. The combination of these factors led to rapid growth of self-insurance in the mid- to late 1970s. Although employers often turned to insurers to administer plans through administrative services only (ASO) contracts, self-insurance became a dominant form of group coverage. Currently the various kinds of plans where the employer group assumes all or a substantial portion of the risk account for 55 percent of total commercial health insurance business, with ASO arrangements accounting for 31 percent and minimum premium plans and stop-loss plans accounting for another 24 percent.

Once self-insurance became an option, community rating was no longer a viable way of determining premiums for groups that were large enough to self-insure. Any group of below-average risk always would be better off to leave the "community" in which it was paying a premium that reflected the risk of the total community including those of higher risk than itself, and self-insure. As a consequence, in recent years not just private insurance carriers but also Blue Cross-Blue Shield plans have been forced to turn to experience rating as the predominant method of premium rating for the types of groups that have the option of self-insuring.

♦The Increasing Visibility of Managed Care

As health care costs rose drastically in the 1970s and 1980s, attention turned to new delivery systems, initially health maintenance organizations (HMOs)and later preferred provider organizations (PPOs). These health care delivery systems (now called managed care) seemed to offer the potential for controlling costs by organizing providers into coherent networks and by integrating the financing and delivery of medical care. In such plans, mechanisms are established to assure the coordination of a broadened range of patient services and to monitor care to assure that it is appropriate and provided in the most efficient and inexpensive way.

At the beginning of 1990, between 50 million and 60 million persons were enrolled in HMOs, independent practice associations, PPOs, exclusive provider organizations and point-of-service plans. Growth of managed care can be expected to continue as new permutations on existing models develop.

Managed care companies are now developing specialty networks for mental health, vision, dental, chiropractic, podiatric and physical therapy care. Sophisticated managed care principles also are being applied to other medically related fields, such as long-term care, and medical bills associated with auto liability and worker's compensation claims.

♦ Major Trends in Coverage, Utilization and Expenditure

From its beginning, the emphasis of health care reimbursement has been on hospital coverage, since the hospital is the center of medical technology. As the scope of health insurance grew and health insurance policies found a niche in the financial plans of the majority of Americans, the dramatic progress of surgical technique and technology, along with their increasing costs, encouraged a demand for surgical coverage. By the 1950s, nearly 60 million people had surgical expense insurance.

A growing realization that physicians were critical to good health care encouraged 21 million people in the 1950s to purchase insurance coverage for physicians' medical fees as well as for surgery. By 1988, Americans spent $50 billion on physicians' services.

During the 1950s and 1960s, most health insurance policies sold by insurance companies contained the three basic coverages for health insurance: hospital care, surgical fees and related physicians' services.

Anticipating the requirements of the insurance-buying public, insurance companies began offering in the 1970s more comprehensive coverages and increased benefit levels that ranged from $50,000 to several million dollars under comprehensive major medical expense policies.

In 1988, public and private health insurance protected 211 million Americans, but more than 31 million persons, many employed by firms that do not offer coverage, were still without health insurance coverage. Many of these people without coverage were poor but still did not qualify for Medicaid.

Commercial insurance companies, Blue Cross-Blue Shield plans, self-funded employer plans and prepayment plans (such as HMOs) cover 90 percent of the people who purchase private coverage. During 1988 these private programs paid more than $170 billion for health care expenses.

From its beginning, health care expense reimbursement focused on hospital expenses as the largest proportion of medical expense dollars. Hospital services are also an important factor in the determination of a large proportion of physician expenses and it became imperative that insurers, both public and private, primarily concern themselves with monitoring the use and costs of hospital services.

In 1988, Americans spent $539.9 billion ($312.4 billion in private funds and $227.5 billion in public funds) for medical and health care services, research and construction of medical facilities. Private insurance companies paid their policyholders $171.1 billion in medical care claims, a $20 billion increase over the previous year.

Rising health care costs continue to be the most pressing problem of the health care system. In 1965, per capita expenditures for health care were $176 in this country. By 1988, the figure had increased to $2,124, an 11-fold increase. During the same 23-year period, health expenditures grew from 5.9 percent of the gross national product to 11.1 percent.

There are three leading reasons for health care cost escalation: (1) increases in coverage have raised levels of expectation and demand; (2) incentives for providers and consumers have encouraged high levels of utilization, discouraged cost consciousness and created tolerance for inefficiency and provision of marginally useful care; and (3) new technologies have usually brought improvements in quality at substantial increases in the cost of treating an episode of illness.

Many important facts about health care coverage, claims payments, services and expenditures are summarized in Table 1.1.

Table 1.1

Key Health Insurance Statistics

	1984	1985	1986	1987	1988	Percent change 1987–1988
Persons with and without health care coverage*(millions)						
Total population	233.4	235.5	238.2	240.5	243.1	1.1
Persons with public and private coverage	202.1	204.2	204.7	208.7	211.6	1.4
Private health insurance	177.4	180.1	180.1	181.1	188.4	4.0
Employer-related	144.3	147.1	145.8	146.7	153.3	4.2
Persons without coverage	31.3	31.3	33.5	31.8	31.5	−0.01
Private health insurance claims payments(billions)**						
Total†	$ 107.5	$ 117.6	$ 128.5	$ 151.7	$ 171.1	12.8
Insurance companies	55.9	59.9	64.3	72.5	83.0	14.5
Blue Cross-Blue Shield	35.7	37.5	40.6	44.5	48.2	8.3
Other plans†	26.0	32.5	36.8	56.5	62.8	11.2
Private health insurance payment by category of service*(billions)**						
Total	$ 121.6	$ 133.2	$ 142.6	$ 155.8	$ 174.6	12.1
Hospital care	56.9	59.3	63.5	69.3	75.0	8.2
Physicians' services	30.4	33.7	38.3	43.9	50.0	13.9
Dentists' services	8.5	9.1	9.9	11.0	12.4	12.7
Other professional services‡	4.6	5.2	6.8	7.0	8.3	18.6
Drugs and medical nondurables	4.7	5.2	6.0	6.9	7.7	11.6
Vision products and other medical durables	0.6	0.7	0.8	0.9	1.0	11.1
Nursing home care	0.3	0.3	0.3	0.4	0.5	25.0
Program administration and cost of private health insurance	17.4	20.0	17.7	16.4	19.7	20.1
National health expenditures*(billions)**						
National health expenditures***	$ 386.9	$ 420.1	$ 450.5	$ 488.8	$ 539.9	10.4
Personal health care	338.7	367.2	397.7	434.7	478.3	10.0
All private funds	227.3	245.2	259.8	280.5	312.4	11.4
All public funds	159.7	174.9	190.7	208.3	227.5	9.2
National health expenditures as percent of GNP	10.3	10.5	10.6	10.8	11.1	2.8
Per capita national health expenditures, private and public	$1,587	$1,700	$1,806	$1,941	$2,124	9.3
Private funds	935	992	1,041	1,114	1,229	10.3
Public funds	652	708	765	827	895	8.2

SOURCES: *United States Bureau of the Census, Current Population Survey.
**Health Insurance Association of America, Source Book Survey.
***Health Care Financing Administration, National Health Expenditure Accounts.

†Other plans include self-insured plans, self-administered plans, plans employing third-party administrators and health maintenance organizations.

‡Other professional services include fees for chiropractors, podiatrists, psychologists, therapists, audiologists, optometrists, portable X-ray suppliers, ambulance service suppliers and free-standing ESRD facilities.

Chapter 2

THE PRIVATE HEALTH INSURANCE INDUSTRY

### ◆ Coverage

At the end of 1988, more than 211 million Americans, or 87 percent of the civilian noninstitutionalized population, were protected by health care coverage. (Table 2.1)

More than 188 million persons were covered by private health insurance with commercial insurance companies, Blue Cross-Blue Shield plans, self-funded employer plans and prepayment plans such as HMOs.

The 1989 HIAA survey of commercial insurance companies found that almost 97 million persons were insured under group policies and nearly 11 million persons carried individual or family policies. (Table 2.2)

Most commercial health insurance companies provide two basic categories of coverage: medical expense insurance and disability income insurance. Medical expense insurance provides broad benefits that can cover virtually all expenses connected with hospital and medical care and related services. Disability income insurance provides periodic payments when the insured is unable to work as a result of sickness or injury.

Blue Cross-Blue Shield nonprofit membership plans serve state and regional areas and offer both individual and group health insurance coverage. The Blue Cross-Blue Shield Association coordinates the Blue Cross-Blue Shield plans of the nation.

Health care coverage also is provided through HMOs offering comprehensive health care services to their members for a fixed periodic payment. In such plans, the HMO is both insurer and provider in the sense of being obligated to furnish needed care as specified in the subscriber's contract.

National growth in HMO membership quintupled in just over a decade, increasing from 6 million people in 1976 to nearly 33 million members enrolled in a total of 590 HMOs in 1989, according to a 1989 InterStudy report.

Self-insurance also plays an important role in the private coverage system. In this arrangement, employers, not insurers, assume the risk, although insurers or third-party administrators (TPAs) may administer the plan.

Plans administered by employers, labor unions, fraternal societies, communities and rural and consumer health cooperatives often make health insurance available to specific groups of people who are not covered under conventional plans.

In 1988, 54 percent of insurance company group coverage was represented by ASO arrangements and MPPs. Under ASO arrangements, corporations and other organizations establish self-funded health plans and pay insurance carriers or private organizations a fee to process claims. Under MPPs, employers self-fund their plans yet insure against very large claims.

More than 71 million persons were covered in 1988 by self-insured plans, self-administered plans, plans employing TPAs and HMOs.

♦ Types of Private Health Insurance

There is an endless variety of policies available in today's health insurance market, all containing a single coverage or combination of coverages available in the following major types of health insurance.

Hospital/Medical Insurance

Hospital expense coverage provides specific benefits for daily hospital room and board and usual hospital services and supplies during hospital confinements.

Room-and-board benefits are usually stated in one of two ways. Indemnity plans reimburse for the actual room-and-board charge up to a specified maximum amount per day for hospital confinement. The second type provides a service-type benefit that pays the full cost of semiprivate room-and-board charge.

Hospital/medical coverage may be provided in one of three ways: (1) a health insurance policy usually sold in combination with a physician's or surgical expense policy that provides benefits for both surgical operations and doctor's inhospital visits; (2) a major medical policy that provides broad and substantial coverage for many types of medical expenses; or (3) a combination of hospital-physician-surgical coverage plus a supplemental major medical policy.

Major Medical Expense Insurance

Major medical expense insurance, introduced nationally by insurance companies in 1951, has grown rapidly. Basically, there are two types of major medical plans. One supplements basic hospital-physician-surgeon expense insurance programs and the other provides comprehensive protection where both basic coverage and extended health care benefits are integrated. Major medical coverage provides broad and substantial protection for large, unpredictable medical expenses. It covers a wide range of medical charges with few internal limits and a high overall maximum benefit.

The majority of major medical policies whether written for individuals or under group plans are subject to some form of deductible and coinsurance payments by the insured person.

Disability Income Protection (Loss of Income)

Disability income coverage provides for the partial replacement of income lost by employees as the result of an accident, illness or pregnancy. Generally, disability income policies are divided into those that provide benefits for up to two years (short-term) and those that provide benefits for a longer period, usually for at least five years, to age 65 or for life (long-term).

When provided on a group basis, the benefits are usually integrated with benefits from Social Security and other public programs. The total level of benefits from these sources generally is set at a level that does not exceed 60 percent of salary.

Individual disability income policies usually provide a fixed dollar amount of coverage. This amount may be greater for those who are turned down by Social Security. Individual disability income policies take many forms and may be designed to fit the special needs of the individual policy owner.

Dental Expense Insurance

Dental expense insurance, generally available through insurance company group plans, prepayment plans and dental service corporations, provides reimbursement for expenses of dental service and supplies and encourages preventive care. The coverage normally provides for oral examinations (including X-rays and cleaning), fillings, extractions, inlays, bridgework and dentures, as well as oral surgery, root canal therapy and orthodontics.

Plans normally include substantial consumer copayments, although the copayments may be lower for preventive services.

Long-Term Care Insurance

The market for insurance coverage that provides the continuation of broad-ranged maintenance and health services to the chronically ill, disabled or retarded began in earnest in 1985 when the number of companies selling this coverage doubled. The services provided by these policies may be provided on an inpatient or outpatient basis or entirely at home.

By December 1989, more than 1.5 million policies covering long-term care had been purchased from 118 insurers in the United States.

Group Self-Insurance

The continuing growth in the number of insurance plans wherein the employer or union assumes all or part of the responsibility for paying claims has made the nation's employers a principal bearer of the financial risks of illness and non-job-related injury in 1988.

There are two basic types of self-insured plans: totally self-insured and MPPs. In a totally self-insured plan, the employer assumes all the risk for paying claims. Under an MPP, the employer pays up to a stop-loss threshold; then an insurer pays or shares in the payment of additional claims. The administration of a self-insured plan includes claims processing, actuarial estimation of plan costs and utilization review.

The responsibilities may be assumed by the employer, an insurance carrier, a TPA or a combination of all three.

These plans, as with fully insured plans, typically cover medical expenses under basic coverage only, major medical coverage only or basic plus major medical coverage. Commercial insurance company and Blue Cross-Blue Shield plans provide employees with basic plus major medical coverage.

The majority of self-insured plans are free-standing major medical plans and do not contain a basic hospital benefit that provides full and unlimited coverage for hospital-related charges. In most self-insured plans, covered services are subject to a deductible and coinsurance.

The growth of self-insurance has been fostered by the lack of state premium taxes and such plans do not have to meet state mandates for minimum benefits.

◆ Employers Offering Health Insurance

In a 1989 survey of 2,621 firms in major industries, HIAA found that virtually all state and local government agencies offer health insurance. (Table 2.4) In service-sector firms, more finance and wholesale firms offer coverage than either transportation or retail firms.

Although a minority of firms offer health insurance in some industries and/or regions, the majority of workers in the United States are employed by firms that offer health insurance. To a large degree, the size of the firm has a bearing on the provision of health benefits; industries dominated by small firms have lower health insurance coverage rates.

Firms with large proportions of employees earning between $10,000 and $30,000 per year are more likely to offer health insurance. (Table 2.5) With small employers, there appears to be a strong, direct relationship between the provision of health insurance and employee turnover rates.

◆ The Population without Health Care Coverage

In recent years, there has been dramatic growth in the number of people who lack either public or private coverage.

Based on Current Population Survey estimates, the number of uninsured persons in this country grew from 28.4 million in 1979 to 31.5 million in 1988, an increase of almost 25 percent.

Other sources place the figure in the range of 37 million persons.

The Population without Health Care Coverage, 1988 (Millions)

	Total population	Number insured	Number without coverage	Percent without coverage
Total population	243.1	201.5	31.5	13.0
Under age 65 population	214.3	182.9	31.4	14.7

SOURCE: U. S. Department of Commerce, Bureau of the Census, Current Population Reports Series P-70, No.17.

The population without health insurance defies stereotype. Contrary to intuition, those who are uninsured are not predominately unemployed. Two-thirds of the uninsured population are in families of full-year steadily employed workers, most of whom were employed full-time. Nearly one-half of uninsured workers (49 percent) are self-employed or employed in firms with fewer than 25 workers. (Employee Benefit Research Institute, *Americans without Health Insurance*, July 1990.)

Several factors are responsible for growth in the uninsured population, including the economic downturn in the early 1980s and its effect on employment; erosion of the Medicaid program's coverage of the poor; demographic shifts; to a small extent, shifts of workers to industries less likely to offer health insurance; and finally, increased health care insurance costs that have outpaced growth in incomes.

Recent studies indicate that uninsured persons span all income groups but are predominantly in low- and middle-income families. The July 1990 survey by Employee Benefit Research Institute (EBRI) indicated that of the nonelderly population, 22.2 percent of the uninsured had incomes of $30,000 or more, 16.5 percent had incomes of $20,000 to $30,000 and the remaining people without health insurance earned salaries from under $10,000 up to $20,000. The federal poverty standard for a family of four in 1989 was $12,091. Fifteen percent of American children under age 18 are uninsured (9.2 million) and two-thirds of these uninsured children are older than 6 years.

In 1989, an HIAA survey of employers found cost to be the most important reason employers gave for not offering coverage. Other important reasons indicated were insufficient profits and no employee interest to provide health insurance coverage.

A Continuing Problem

Large numbers of uninsured people pose a major national problem for a variety of reasons. First, there is growing evidence that uninsured persons have difficulty gaining access to the health care system and, if and when they do, it is often too late or more costly to treat the health problem. Second, the cost of this care is borne indirectly by providers and insurers through the cost of "unsponsored care" or cost shifting. It has been estimated that the uninsured population is responsible for as much as 70 percent of unsponsored care.

♦ Health Insurance Claims

In 1988, private health insurers in the United States paid a total of $171.1 billion for medical care and disability claims (Table 2.6), a 13 percent increase since 1987. Commercial insurance companies paid nearly one-half ($83 billion). This represents a 14.5 percent increase over the $72.5 billion paid in 1987.

Blue Cross-Blue Shield plans paid more than $48.2 billion in benefits in 1988. Self-insured and HMO plans recorded $62.8 billion in paid claims for the same period.

Hospital and medical expense claims paid by commercial insurers included payments under hospital, surgical, physician expense and major medical insurance, and totaled $63.3 billion in 1988, an increase of 16 percent since 1987. (Table 2.7) Dental claim payments totaled $6.3 billion in 1988.

Policies purchased to supplement Medicare coverage provided $2.2 billion to claimants. Loss of income claims, including both short-term and long-term disability, cost insurance companies $4.6 billion in 1988.

In the 1970s, many group insurance buyers began to turn to ASO and MPP instead of traditional insured plans. In 1987, only 24.8 percent of the total group claims payments (Table 2.8) came from ASOs and MPPs. By 1988, these two types of arrangements accounted for more than 53 percent of the total group claims of $76.4 billion paid by insurance companies.

An HIAA survey of the 20 leading writers of health insurance conducted in July 1989 indicated an underwriting loss of 4.6 percent for group insurance, a continuation of the downward trend that began in 1986.

Individual health insurance showed an even more alarming 8.4 percent underwriting loss.

The survey represents companies that write approximately 55 percent of the total group health insurance premiums and approximately 35 percent of the total individual health insurance premiums written by commercial insurance companies in the United States.

The dollar totals noted in this chapter refer to incurred claims. Premium figures reported are on an earned basis for the calendar year to reflect a true picture of premiums for the year.

Additions to claim reserves for persons already disabled are extracted from current year premiums but not reflected in the claims payments.

These claim reserves will be used to make future disability income payments under the contracts.

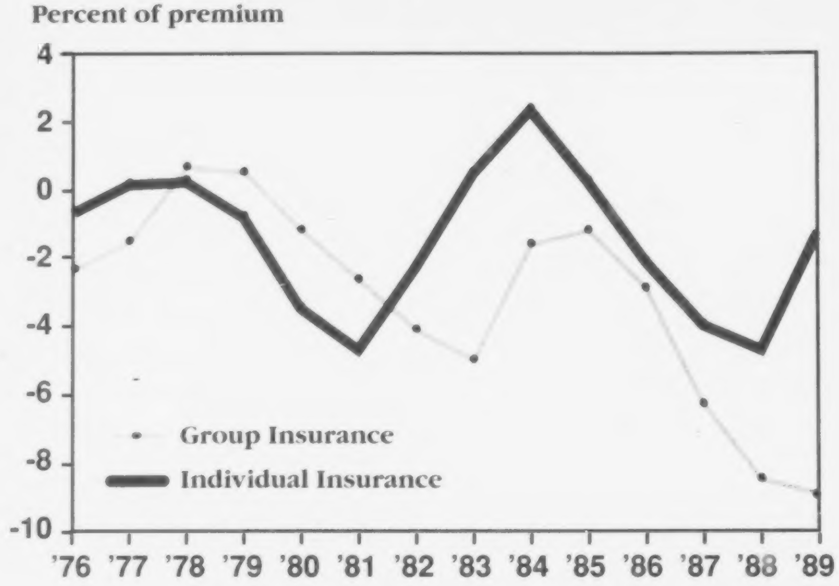
♦ Health Insurance Premiums

In 1988, health insurance premium income of all private insuring organizations was $192.3 billion. (Table 2.10)

Insurance companies earned $98.2 billion in premiums in 1988; 89 percent of these premium dollars were for group insurance coverage. Americans spent 6 percent of disposable personal income (personal income minus personal taxes) in 1988 for health insurance premiums, compared to 5.3 percent in 1987.

Leading Health Insurers

Net Underwriting Results 1976–1989



SOURCE: Health Insurance Association of America.

Group and Individual Premiums

Group health insurance premiums have been increasing substantially for many years. The major contributing factor to this growth in premiums is an increase in health care costs.

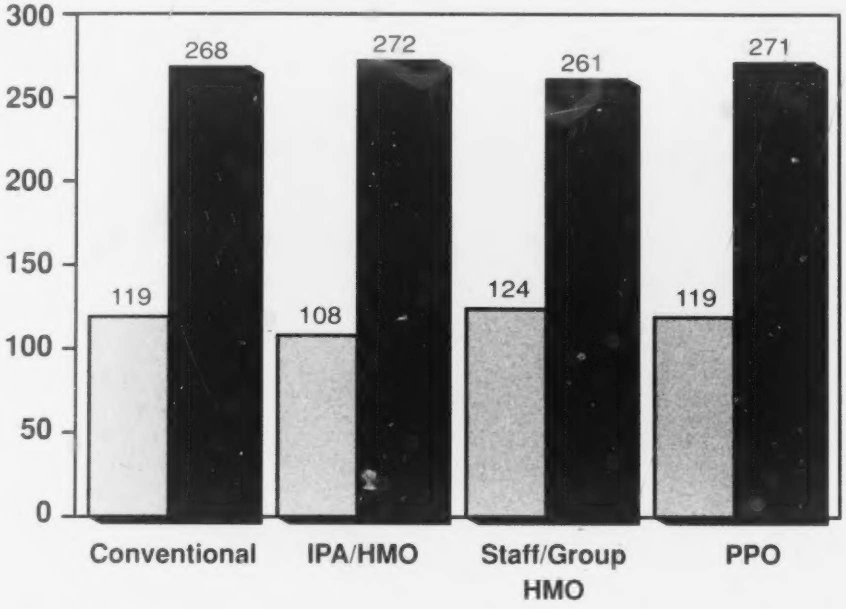
In 1988, insurance companies earned $87.6 billion in group premiums and $10.6 billion in individual and family policy premiums. During this year, 52 percent of the group premiums were accounted for by self-insured arrangements. (For this analysis, premiums for self-insured plans [ASO and MPP] are defined as the sum of claims paid plus the insurer's administrative fee. (Table 2.12)

A recent HIAA survey of 2,621 large, mid-sized and small employers from the public and private sectors found that in 1989 the average monthly premium for coverage in a conventional plan was $119 for an individual and $268 for a family.

For HMO coverage, it was $108 for an individual and $272 for a family. For PPOs the monthly premium was $119 for an individual and $271 for a family.

Monthly Premium Cost for Conventional, HMO and PPO Plans by Type of Plan, 1989

(Monthly premium in dollars)



SOURCE: Health Insurance Association of America.

Insurance company premiums reported in Tables 2.11 and 2.13 are on an earned basis for the calendar year (earned premiums are defined as the calendar-year portion of premiums for which the protection of the policy has been provided.)

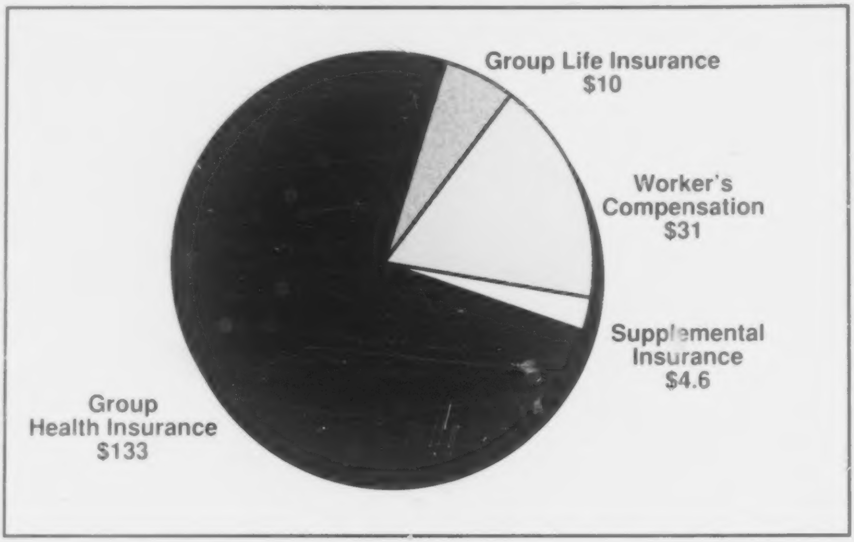
PPOs and fee-for-service plans with preadmission certification increased their market share during the past year.

According to the HIAA survey, nearly 23 percent of individuals covered by employer-sponsored health insurance are members of an HMO; another 32 percent are covered by a PPO. In the South, HMOs account for less than 8 percent of the market, whereas PPOs account for 10 percent.

In the Northeast, PPOs' market share is only 3 percent.

Dollar Outlay by Employers for Employee Insurance Coverage (1988)

(from total compensation)



SOURCE: U. S. Department of Commerce, Bureau of Economic Analysis, Survey of Current Business.

Insurance Premiums Paid by Employers

Between 1970 and 1980, the amount of insurance premiums paid by American employers for their employee group insurance policies increased by 352 percent. During the mid-1980s, premium increases were between 6 percent and 8 percent annually, but by 1988 premium increases were in double digits again. The pie chart on this page shows that in 1988 employers contributed $133 billion for group health insurance to benefit their employees.

♦ The Evolution of Managed Care

During the past 5 to 10 years, the health care delivery and financing system has evolved at a pace that few expected, largely responding to the acute concern about the ever-rising cost of care. The most visible change has been the explosion of what are becoming known as managed care delivery systems, of which HMOs and PPOs are the best-known examples.

A Definition of Managed Care

Although managed care is still responding to changes in medical practice and the needs of consumers and payers, it can be defined as a system that integrates the financing and delivery of appropriate health care services to covered individuals and has the following common elements:

- Arrangements with selected providers to furnish a comprehensive set of health care services to members;
- Explicit standards for the selection of health care providers;
- Formal programs for ongoing quality assurance and utilization review; and
- Significant financial incentives for members to use providers and procedures covered by the plan.

Managed care plans employ a variety of techniques to assure quality and appropriateness of care including utilization review, case management and the use of primary care physicians as coordinators and managers of care.

A variety of managed care models are in place and others will develop as the concept evolves.

History of Managed Care

Managed care began in the 1930s when the first prepaid group practices were established. The founders of this early type of managed care saw this model for integrating the financing and delivery of care as a way to improve quality and continuity of care and as a vehicle to provide preventive health care services.

Health Maintenance Organizations (HMOs). The early prepaid group practices are one example of what are now known as HMOs. Since the 1930s, the HMO delivery system has evolved into a variety of forms, especially in the past two decades. The characteristic they share is that they provide a defined, comprehensive set of health services to a voluntarily enrolled population within a specified geographic service area. Providers are typically reimbursed on a capitated or other "at risk" arrangement. There are a number of models. The group model, of which Kaiser Permanente is perhaps the best-known example, involves a physician medical group contracting with the entity that is financially responsible for covering enrollees. In the staff model, physicians are employees of the HMO. In the network model, the HMO contracts with two or more independent group practices. The independent practice association (IPA) HMO contracts with a number of individual physicians in independent practices or with associations of independent physicians; IPA physicians often have arrangements with more than one HMO. The most recent model is the point-of-service HMO, sometimes known as an open-ended HMO. This model gives enrollees the option to choose providers outside the plan at the time they seek care for a particular condition, but there is a strong financial incentive to use the affiliated providers.

Although there was some growth in HMOs from the 1930s through the 1960s, particularly on the West Coast, interest in this alternative delivery system was sparked by the unanticipated rapid increases in health care costs that the country experienced in the late 1960s and 1970s. HMOs seemed to solve the cost problem by managing care to economize on services, particularly by reducing rates of hospitalization.

In 1973, in response to rising health care costs, Congress enacted legislation to promote HMO growth. The HMO Act, P.L. 93-222, authorized federal funds to establish and develop HMOs over a period of five years. The act required most employers to offer an HMO option to employees where federally qualified HMOs were available. To meet the qualification test, HMOs had to provide a prescribed range of basic health services and to offer the subscriber the opportunity to purchase optional health services.

In response to the favorable cost record of HMOs, Medicare and Medicaid also turned to HMOs with the hope that they could help bring the costs of these federal programs under control. Medicare participants in HMOs now number about 1 million. Medicaid increased its HMO enrollment from 282,000 in 1981 to 947,000 in 1987.

Overall, HMO growth has been rapid; enrollment increased from less than 2 million in the early 1970s to almost 35 million in 1989. By year end 1989, slightly more than 13 percent of all Americans were enrolled in 591 HMOs, with plans in every state except Alaska and Mississippi.

Preferred Provider Organizations (PPOs). The other prominent example of managed care is the PPO. Developed during the 1980s, the PPO offers more flexibility than the HMO, giving consumers greater freedom in choosing providers but, as with the HMO, it tries to achieve savings by directing patients to providers who are committed to cost-effective delivery of care.

PPOs are financing and delivery systems that combine features of standard fee-for-service indemnity plans and HMOs. Typically organized by insurers but sometimes by providers or others, PPOs have contracts with networks or panels of providers who agree to provide medical services and to be paid according to a negotiated fee schedule. Individuals who are enrolled in the PPO typically experience a financial penalty if they choose to get care from a nonaffiliated provider, but that option is available. Ideally, providers are chosen for their efficiency, and the system includes various kinds of monitoring and controls to assure that care is efficiently provided.

The exclusive provider organization (EPO) is the extreme of the PPO. Services rendered by nonaffiliated providers are not reimbursed, so people belonging to an EPO must receive their care from affiliated providers or pay the entire cost out of pocket. Providers typically are reimbursed on a fee-for-service basis according to a negotiated discount or fee schedule.

The distinctions among HMOs, PPOs and EPOs are becoming blurred. As cost containment pressures continue and as these alternative delivery systems try to increase their market share, each tries to determine how to make the system more attractive. Often that means borrowing features from others. It is likely that the evolution will continue so that it will become increasingly difficult to characterize a particular managed care delivery system as adhering to any particular model.

Current Trends

HMO growth, which had been very rapid in recent years, slowed in 1989. Sustaining the rapid growth rate of the previous five years would have been difficult. If growth had continued at the compound rate of the 22 percent which characterized the years between 1983 and 1988, HMOs would have enrolled the entire population of the United States by the year 2000.

HMOs currently enroll more than 13 percent of the population, with six states having more than 20 percent of their populations in HMOs. (Table 2.15) California, with almost 30 percent, has the highest HMO enrollment in both relative and absolute terms.

Large HMOs (more than 100,000 members) grew at a rapid pace by the end of 1989, adding more than 1 million members in the six months ending in January 1990. Although there are now 84 HMOs in the United States each with more than 100,000 membe 85 percent of all HMOs have fewer than 100,000 enrollees.

The structure of HMOs is changing, becoming hybrid and more diversified. The Group Health Association of America reports that in 1988, among plans more than three years old, 47 percent added PPOs, indemnity options, open-ended options, freestanding utilization review services or employee assistance programs to assist individuals with substance abuse or mental health problems. A small proportion also offered worker's compensation services. An increasing number of HMOs are offering a point-of-service option.

PPOs, primarily a phenomenon of the 1980s, also are growing rapidly. They have increased in number from 572 in 1987 to 685 in 1989, and at the end of 1988, 36 million people had access to a PPO, according to the American Managed Care and Review Association.

Outlook for the Future

The recent rapid growth of managed care plans reflects the recognition by major employers and insurers that ways must be found to reduce costs while assuring that patients get appropriate care. Insurers increasingly recognize that traditional fee-for-service indemnity plans do not provide mechanisms to contain costs. As a consequence, many insurers have made major commitments to develop and sustain comprehensive managed care systems.

Table 2.1

Health Care Coverage in the United States in Selected Years (Millions)

Characteristics	1984	1985	1986	1987	1988
Total population	**233.5**	**235.5**	**238.2**	**240.4**	**243.1**
People with health care coverage, public and private					
Total*	202.1	204.2	204.4	208.2	211.6
Percent of total population	86.6	86.7	85.8	86.6	87.1
Age of those covered					
0 to 64 years	175.6	177.2	176.8	179.9	182.8
65 and more years	26.5	27.1	27.5	28.3	28.8
Race					
White	174.2	175.2	175.2	176.2	181.3
Black	22.1	23.0	23.1	23.2	23.7
Hispanic**	10.1	10.4	12.9	13.4	14.6
People with private insurance					
Total	177.4	180.1	180.1	183.2	188.4
Percent of total population	76.0	76.5	75.6	76.2	77.5
Age of those covered					
0 to 64 years	158.1	159.6	159.3	161.9	166.5
65 and more years	19.3	20.5	20.7	21.2	21.9
Race					
White	157.7	159.3	158.5	159.2	166.5
Black	15.3	15.9	16.3	16.9	16.5
Hispanic	7.6	7.8	9.8	9.9	11.4

*NOTE: Totals may not add due to rounding or duplication.

**NOTE: Hispanic may contain persons of any race.

SOURCE: Current Population Survey, U.S. Department of Commerce, Bureau of the Census.

Table 2.2

Number of Persons with Private Insurance Protection by Type of Insurer (Millions)

Year	All insurers*	Insurance companies Total*	Group	Individual/ family	Blue Cross-Blue Shield	Other plans**
1940	12.0	3.7	2.5	1.2	6.0	2.3
1945	32.0	10.5	7.8	2.7	18.9	2.7
1950	76.6	37.0	22.3	17.3	38.8	4.4
1955	101.4	53.5	38.6	19.9	50.7	6.5
1960	122.5	69.2	54.4	22.2	58.1	6.0
1961	125.8	70.4	56.1	22.4	58.7	7.1
1962	129.4	72.2	58.1	23.1	60.1	6.9
1963	133.5	74.5	61.5	23.5	61.0	7.2
1964	136.3	75.8	63.1	34.0	62.1	6.8
1965	138.7	77.6	65.4	24.4	63.3	7.0
1966	142.4	80.4	67.8	24.9	65.3	6.6
1967	146.4	82.6	71.5	24.6	67.2	7.1
1968	151.9	85.7	74.1	25.3	70.1	7.3
1969	155.0	88.8	77.9	25.9	72.7	7.7
1970	158.8	89.7	80.5	26.7	75.1	8.1
1971	161.8	91.5	80.6	27.8	76.5	8.5
1972	164.1	93.7	81.5	29.1	78.2	8.1
1973	168.5	94.5	83.6	27.5	81.3	9.6
1974	173.1	97.0	85.4	28.8	83.8	11.1
1975	178.2	99.5	87.2	30.1	86.4	13.1
1976	176.9	97.0	86.8	27.0	86.6	14.9
1977	179.9	100.4	89.2	28.7	86.0	18.1
1978	185.7	106.0	92.6	36.1	85.8	21.5†
1979	185.7	104.1	94.1	34.4	86.1	25.5†
1980	187.4	105.5	97.4	33.8	86.7	33.2†
1981	186.2	105.9	103.0	25.3	85.8†	40.3†
1982	188.3	109.6	103.9	29.4	82.0†	48.2†
1983	186.6	105.9	104.6	22.2	79.6†	53.6†
1984	184.4	103.1	103.0	20.4	79.4†	54.4‡
1985	181.3	100.4	99.5	21.2	78.7†	55.1‡
1986	180.9	92.5	95.2***	11.7***	78.0†	64.9‡
1987	179.7	91.0	94.7***	10.0***	76.9†	66.9‡
1988	182.3	93.3	96.8***	10.7***	74.0†	71.3‡

*The data in these columns refer to the net total of persons protected, i.e., duplication among persons protected by more than one kind of insuring organization or more than one insurance company policy providing the same type of coverage has been eliminated.

**Other plans include self-insured plans, self-administered plans, plans employing third-party administrators and health maintenance organizations.

***Excludes hospital indemnity coverage, which had been included in prior years. For 1988, group hospital indemnity coverage was 8.3 million individuals and individual hospital indemnity was 6.5 million individuals.

†Estimate.

‡For 1984 and later, estimates of persons covered by "other plans" have been developed by HIAA in the absence of other available data.

NOTE: Some data were revised from previous editions. Data for 1978 and later have been adjusted downward due to new data on average family size. For 1975 and later, data include the number of persons covered in Puerto Rico and U. S. territories and possessions. Persons covered under insurance company ASO agreements and MPPs are included in the categories. All Insurance companies and group policies.

NOTE: Data for 1987 and 1988 reflect the revised HIAA survey form.

SOURCES: Health Insurance Association of America, Blue Cross and Blue Shield Association, U.S. Department of Health and Human Services and Group Health Association of America.

Table 2.3

Health Insurance Coverage by Age and Race (1986–1988) (Percent)

Status	1986	1987	1988
Total population	238,179,000	240,493,000	243,094,000
Percentage covered by private or government health insurance			
Total	85.9	86.8	87.0
Age:			
Less than 16 years	83.6	84.3	84.7
16 to 24 years	76.2	78.0	78.0
25 to 34 years	83.2	84.0	83.8
35 to 44 years	87.9	88.4	88.8
45 to 54 years	88.6	88.8	89.5
55 to 64 years	89.7	90.6	90.7
65 years and more	99.5	99.6	99.7
Race and Hispanic origin:			
White	87.1	87.8	88.3
Black	79.4	81.0	79.8
Hispanic origin	69.2	70.4	73.5
Covered by private health insurance			
Total	75.4	76.5	77.5
Age:			
Less than 16 years	69.2	69.7	71.2
16 to 24 years	68.9	70.9	71.4
25 to 34 years	75.8	77.0	77.6
35 to 44 years	82.3	82.6	83.2
45 to 54 years	82.8	83.6	84.6
55 to 64 years	82.1	83.3	83.6
65 years and over	75.8	77.9	79.0
Race and Hispanic origin:			
White	78.7	79.9	81.0
Black	54.9	56.1	55.3
Hispanic origin	50.8	53.9	57.4
Covered by private health insurance related to employment of self or other family member			
Total	61.1	62.0	63.1
Age:			
Less than 16 years	59.7	60.8	61.9
16 to 24 years	53.9	54.6	55.7
25 to 34 years	67.7	69.1	70.1
35 to 44 years	74.5	74.4	75.2
45 to 54 years	72.4	73.3	74.7
55 to 64 years	66.5	66.9	68.0
65 years and more	33.3	34.3	35.0
Race and Hispanic origin:			
White	63.7	64.6	65.7
Black	45.4	46.2	46.8
Hispanic origin	43.5	45.9	48.6

Continued

Percent covered by Medicaid			
Total	7.2	7.3	7.1
Age:			
Less than 16 years	13.1	13.4	12.5
16 to 24 years	6.3	6.4	6.6
25 to 34 years	5.9	5.5	5.0
35 to 44 years	4.1	4.2	4.4
45 to 54 years	3.3	3.5	3.7
55 to 64 years	4.4	4.6	4.2
65 years and more	7.9	8.1	8.3
Race and Hispanic origin:			
White	5.2	5.1	4.9
Black	20.5	21.7	20.6
Hispanic origin	15.9	14.3	14.1

SOURCES: Health Insurance Coverage 1986–88 by Charles Nelson and Kathleen Short; Current Population Reports; Household Economic Studies; Survey of Income Participation; U.S. Department of Commerce, Bureau of the Census.

Table 2.4

Percent of Firms Offering Health Coverage by Associated Industry

	Percent of labor force	All firms	Number of employees				Percent of employees in firms offering coverage
			1–9	10–24	25–99	100+	
Total	100	42	33	72	90	99	77
Government*	5	99	100	75	100	100	98
Agriculture**	3	50	40	100	100	100	76
Mining	1	37	**	***	**	**	94
Construction	7	39	29	83	**	90	64
Manufacturing	19	55	44	83	97	99	91
Transportation	7	33	25	**	**	100	75
Wholesale trade	4	51	39	83	**	98	78
Retail trade	17	32	24	55	78	93	63
Finance & insurance	7	60	54	**	**	100	90
Business services	32	35	29	69	90	99	76

*Excludes federal government employees.
**Insufficient sample.
***No responders in this cell.

SOURCES: Health Insurance Association of America, Bureau of Labor Statistics, January 1988.

Table 2.5

The Relationship of Wages to Providing Health Benefits

	Offer health benefits			Do not offer health benefits		
	Percent of employees earning			Percent of employees earning		
Size of firm	Less than $10,000	$10,000–$30,000	More than $30,000	Less than $10,000	$10,000–$30,000	More than $30,000
Fewer than 10 employees	11	60	28	30	53	18
10–24 employees	16	62	22	47	41	12
25–99 employees	11	69	20	42	43	*
100 or more employees	13	65	22	52	38	*

*Insufficient sample.

SOURCE: Health Insurance Association of America.

Table 2.6

Private Health Insurance Claims Payments by Type of Insurer (Billions)

Year	Insurance companies	Blue Cross-Blue Shield	Self-insured & HMO plans	Total
1950	$ 0.8	$ 0.6	NA	$ 1.3
1955	1.8	1.4	NA	3.1
1960	3.0	2.6	NA	5.7
1965	5.2	4.5	NA	9.6
1970	9.1	8.1	NA	17.2
1975	16.5	16.9	NA	32.1
1980	37.0	25.5	$16.2	76.3
1981	41.6	29.2	18.9	85.9
1982	49.2	32.2	21.6	97.1
1983	51.7	34.4	24.1	104.1
1984	56.0	35.7	26.1	107.5
1985	60.0	37.5	32.5	117.6
1986	64.3	40.6	36.8	128.5
1987	72.5	44.5	56.5	151.7
1988	83.0	48.2	62.8	171.1

SOURCE: Health Insurance Association of America, Annual Survey of Health Insurance Companies.

Table 2.7

Group Health Claims Payments of Insurance Companies by Type of Coverage (Billions)

Year	Total group	Hospital/ Medical	Dental	Medicare supplement	Loss of income
1950	$ 0.4	NA	NA	NA	NA
1955	1.3	NA	NA	NA	NA
1960	2.4	$ 1.8	NA	NA	$0.8
1965	4.0	3.3	NA	NA	1.0
1970	7.5	6.0	$0.1	NA	1.8
1975	14.2	11.6	0.6	NA	2.7
1980	33.0	25.8	2.8	$0.1	4.3
1981	37.7	30.0	3.5	0.2	4.2
1982	44.2	35.9	4.0	0.1	4.1
1983	46.9	38.6	4.4	0.1	3.9
1984	50.3	41.1	4.9	0.4	3.9
1985	53.7	43.9	5.3	0.5	4.0
1986	58.9	48.1	5.3	1.5	4.0
1987	66.5	54.6	5.9	1.5	4.6
1988	76.4	63.3	6.3	2.2	4.6

SOURCE: Health Insurance Association of America, Annual Survey of Health Insurance Companies.

Table 2.8

Group Health Claims Payments of Insurance Companies by Type of Risk Management (Billions)

		Fully insured		Administrative services only		Minimum premium plan	
Year	Total group	Hospital/ Medical	Loss of income	Hospital/ Medical	Loss of income	Hospital/ Medical	Loss of income
1950	$ 0.4	NA	NA	NA	NA	NA	NA
1955	1.3	NA	NA	NA	NA	NA	NA
1960	2.4	$ 1.8	NA	NA	NA	NA	NA
1965	4.0	3.3	NA	NA	NA	NA	NA
1970	7.5	6.0	NA	NA	NA	NA	NA
1975	14.2	11.6	NA	NA	NA	NA	NA
1980	33.9	21.7	$3.8	$ 2.2	$0.2	$ 5.6	$0.4
1981	37.7	19.8	3.2	3.6	0.3	10.2	0.7
1982	44.2	21.7	3.0	5.4	0.4	13.0	0.8
1983	46.9	22.8	2.9	5.7	0.2	14.5	0.7
1984	50.3	20.6	2.7	9.7	0.4	16.1	0.8
1985	53.7	21.5	2.8	11.8	0.5	16.3	0.8
1986	58.9	23.1	2.7	14.1	0.7	17.7	0.6
1987	66.5	27.8	3.0	17.8	0.9	16.4	0.7
1988	76.4	32.5	3.1	22.0	0.9	17.4	0.5

SOURCE: Health Insurance Association of America, Annual Survey of Insurance Companies.

Table 2.9

Individual Health Insurance Claims Payments of Insurance Companies by Type of Coverage (Billions)

Year	Total individual	Hospital/ Medical	Loss of income
1978	$3.5	$2.5	$1.0
1979	3.8	2.6	1.1
1980	4.0	3.0	1.0
1981	3.9	3.0	1.0
1982	4.5	3.6	1.4
1983	4.8	3.8	1.0
1984	5.7	4.4	1.3
1985	6.3	4.7	1.6
1986	5.4	3.8	1.6
1987	5.9	4.1	1.8
1988	6.6	4.7	1.8

SOURCE: Health Insurance Association of America, Annual Survey of Insurance Companies.

Table 2.10

Health Insurance Premiums of Insurance Companies, Self-Insured and HMO Plans and Blue Cross-Blue Shield

Year	Net total*	Insurance companies	Self-insured and HMO plans	Blue Cross-Blue Shield
1950	$ 2.0	$ 1.3	$ NA	$ 0.7
1955	4.3	2.7	NA	1.5
1960	7.5	4.7	NA	2.8
1965	12.1	7.4	NA	4.8
1970	20.0	11.5	NA	8.4
1975	37.0	20.8	NA	17.6
1980	84.7	43.7	17.3	26.3
1981	95.1	49.0	20.0	30.4
1982	109.5	58.3	22.9	34.3
1983	119.9	63.2	25.6	37.6
1984	127.6	70.4	28.6	40.0
1985	139.5	75.2	36.7	41.5
1986	143.4	75.5	40.6	43.5
1987	168.6	84.1	61.7	46.3
1988	192.3	98.2	73.7	51.2

*All insurers. Does not add to sum of types because of duplication among types.

SOURCE: Health Insurance Association of America, Annual Survey of Insurance Companies.

Table 2.11

Group Health Insurance Premiums of Insurance Companies by Type of Coverage (Billions)

Year	Total group	Hospital/ Medical	Dental	Medicare supplement	Loss of income
1980	$36.8	$28.2	$3.2	$0.0	$5.3
1981	42.5	33.0	4.1	0.1	5.2
1982	50.0	39.6	4.8	0.1	5.5
1983	54.9	44.4	5.3	0.1	5.1
1984	60.8	49.6	5.7	0.5	5.0
1985	64.4	52.7	6.2	0.6	4.8
1986	65.9	53.0	6.2	1.8	5.0
1987	74.0	59.9	6.8	1.8	5.5
1988	87.6	71.9	7.8	2.5	5.5

SOURCE: Health Insurance Association of America, Survey of Health Insurance Companies.

Table 2.12

Group Health Insurance Premiums of Insurance Companies by Type of Risk Management (Billions)

		Fully insured		Administrative service only		Minimum premium plan	
Year	Total group premiums	Hospital/ Medical	Loss of income	Hospital/ Medical	Loss of income	Hospital/ Medical	Loss of income
1980	$36.8	$23.0	$4.6	$ 2.4	$0.2	$ 6.1	$0.5
1981	42.5	22.4	4.1	4.0	0.3	10.9	0.9
1982	50.0	24.6	4.2	5.7	0.4	14.2	0.9
1983	54.9	27.5	3.8	6.1	0.5	16.2	0.9
1984	60.8	26.9	3.5	10.7	0.5	18.2	1.0
1985	64.4	27.6	3.5	13.1	0.6	18.8	0.8
1986	65.9	27.1	3.4	15.4	0.8	18.4	0.8
1987	74.0	30.7	3.7	18.7	1.0	19.1	0.7
1988	87.6	36.9	3.8	25.2	1.1	20.0	0.6

SOURCE: Health Insurance Association of America, Survey of Health Insurance Companies.

Table 2.13

Individual Insurance Premiums of Insurance Companies by Type of Coverage (Billions)

Year	Total individual	Hospital/ Medical	Loss of income
1980	$ 6.9	$4.9	$2.0
1981	6.5	4.7	1.8
1982	8.3	5.8	2.5
1983	8.3	6.3	2.0
1984	9.6	7.2	2.4
1985	10.8	7.9	2.9
1986	9.6	6.7	2.9
1987	10.1	7.0	3.1
1988	10.6	7.4	3.2

SOURCE: Health Insurance Association of America, Survey of Health Insurance Companies.

Table 2.14

Underwriting Results for Insurance Companies and Blue Cross-Blue Shield Plans (1984–1988)

	1984	1985	1986	1987	1988
Insurance Companies					
Number of companies	702	677	636	646	646
Underwriting loss/gain* (millions)	($108.2)	($389.2)	($1,952.1)	($3,689.1)	($3,780.9)
Blue Cross-Blue Shield					
Number of organizations	60	55	54	47	43
Underwriting loss/gain* (millions)	$2,069.7	$1,578.1	$250.9	($1,907.9)	$1,086.7

NOTE: The number of companies providing claims data for Argus Heatlh Charts does not represent the same number of companies represented by HIAA data.

*Includes expenses incurred.

SOURCE: National Underwriter Company, Argus Health Charts, various years.

Table 2.15

HMO Enrollment and Percent of Population in HMOs by State (1989)

Number of HMOs	State	Enrollment	Percent of population in HMOs
590	Total	32,492,784	13.2
8	Alabama	180,624	4.4
0	Alaska	0	0.0
16	Arizona	597,896	17.1
5	Arkansas	55,739	2.3
51	California	8,439,810	29.8
17	Colorado	657,637	19.9
13	Connecticut	621,260	19.2
6	Delaware	118,247	17.9
4	District of Columbia	449,534	72.9
35	Florida	1,300,862	10.6
8	Georgia	285,616	4.5
3	Guam	58,337	44.7
6	Hawaii	240,815	21.9
2	Idaho	19,878	2.0
28	Illinois	1,513,833	13.0
12	Indiana	399,916	7.2
8	Iowa	222,270	7.8
11	Kansas	208,153	8.3
7	Kentucky	205,688	5.5
9	Louisiana	237,110	5.4
3	Maine	24,903	2.1
12	Maryland	684,656	14.8
19	Massachusetts	1,455,308	24.7
17	Michigan	1,408,058	15.3
10	Minnesota	767,041	17.8
0	Mississippi	0	0.0
17	Missouri	526,802	10.2
1	Montana	2,858	0.4
5	Nebraska	61,798	5.1
2	Nevada	93,157	8.8
3	New Hampshire	113,058	10.4
16	New Jersey	879,465	11.4
5	New Mexico	190,507	12.6
37	New York	2,567,431	14.3
12	North Carolina	326,679	5.0
2	North Dakota	20,047	3.0
34	Ohio	1,294,173	11.9
6	Oklahoma	169,032	5.2
10	Oregon	652,044	23.6
20	Pennsylvania	1,257,801	10.5
4	Rhode Island	212,612	21.4
6	South Carolina	74,665	2.2
1	South Dakota	28,540	4.0
8	Tennessee	231,096	4.7
29	Texas	1,197,199	7.1
6	Utah	226,178	13.4
1	Vermont	26,571	4.8
14	Virginia	386,318	6.4
10	Washington	655,428	14.1
1	West Virginia	66,482	3.5
30	Wisconsin	1,056,078	21.8
1	Wyoming	2,594	0.5

SOURCE: InterStudy. The InterStudy Edge 1989, Vol. 4.

Table 2.16

Number of HMOs and HMO Enrollment by Selected Characteristics (1989)

	Plans		Enrollment	
	Number of plans	Percent of total	Number of enrollees	Percent of total
All plans	**591**	**100.0**	**34,748,354**	**100.0**
Model type				
Staff	61	10.3	4,304,674	12.4
Group	80	16.5	10,397,738	29.9
Network	89	15.1	5,174,325	11.9
IPA	361	61.1	14,861,617	42.8
Region				
New England	44	7.4	2,552,788	7.4
Mid-Atlantic	71	12.0	4,763,921	13.7
South Atlantic	95	16.1	3,809,029	11.0
East Central	149	25.2	6,684,725	19.2
West Central	104	17.6	4,313,142	12.4
Mountain/Pacific	128	21.6	12,624,750	36.4
Plan size				
0–19,999 individuals	242	40.9	2,302,312	6.6
20,000–49,999 individuals	178	30.1	5,463,199	15.7
50,000–99,999 individuals	82	13.9	5,791,543	16.7
100,000 or more individuals	89	15.1	21,191,300	61.0
Plan age				
1 year	19	3.2	124,935	0.4
2–3 years	95	16.1	1,362,401	3.9
4–7 years	284	48.1	9,512,863	27.4
8–15 years	126	21.3	11,413,227	32.8
16+ years	67	11.6	12,334,928	35.5
Tax status				
Nonprofit	207	35.0	18,759,157	54.0
Profit making	384	65.0	15,989,197	46.0
Qualification status				
Federally qualified	344	52.6	26,273,581	75.6
Nonqualified	280	47.4	8,474,773	24.4

SOURCE: Group Health Association, HMO Magazine, May–June 1990.

Table 2.17

Percent of Health Plans Providing Coverage for Specific Services by Plan Type (1988–1989)

	Conventional insurance plan		PPO plan		HMO IPA plan		HMO staff plan	
Benefits	1988	1989	1988	1989	1988	1989	1988	1989
Adult physical examinations	27	34	39	42	95	95	99	99
Well-baby care	45	50	62	62	99	98	97	99
Preventive diagnostic procedures	61	67	72	71	96	94	100	100
Prescription drugs	93	NA	94	NA	95	NA	92	NA
Home health care	84	73	90	75	90	90	86	88
Mental health								
Outpatient	94	90	97	91	96	98	95	99
Inpatient	98	95	96	95	98	99	97	97
Treatment for substance abuse	87	NA	93	NA	98	NA	98	NA
Alcohol	NA	85	NA	88	NA	95	NA	98
Drugs	NA	86	NA	87	NA	96	NA	98
General dental care	42	37	33	39	16	17	26	11
Orthodontia	30	NA	26	NA	8	NA	18	NA
Cost containment								
Preadmission certification	65	73	92	85	NA	NA	NA	NA
Concurrent utilization review	65	65	79	79	NA	NA	NA	NA
Review laboratory tests before hospital admission	34	NA	53	NA	NA	NA	NA	NA
Mandatory second opinion for surgery	51	53	63	62	NA	NA	NA	NA
Case management for large claims	51	59	78	58	NA	NA	NA	NA
Incentives to buy generic drugs	28	NA	NA	NA	NA	NA	NA	NA
Incentives to use ambulatory surgery	54	NA	67	NA	NA	NA	NA	NA

SOURCE: Health Insurance Association of America, 1989.

Table 2.18

Operational PPOs by State and Selected Regions (1987–1989)

States	1987	1988	1989
Total United States	572	618	685
Alabama	8	6	7
Alaska	2	0	0
Arizona	27	22	13
Arkansas	4	2	1
California	98	104	152
Colorado	29	31	24
Connecticut	4	4	90
Delaware	1	0	0
District of Columbia	9	6	3
Florida	37	40	25
Georgia	17	17	16
Hawaii	2	2	2
Idaho	0	0	0
Illinois	32	32	34
Indiana	10	9	7
Iowa	3	3	3
Kansas	7	10	6
Kentucky	9	8	8
Louisiana	12	11	13
Maine	0	0	0
Maryland	12	9	15
Massachusetts	11	13	37
Michigan	17	17	8
Minnesota	14	11	7
Mississippi	2	1	3
Missouri	22	20	11
Montana	0	0	0
Nebraska	3	3	2
Nevada	9	6	6
New Hampshire	1	0	1
New Jersey	4	2	5
New Mexico	7	2	2
New York	8	10	7
North Carolina	11	10	9
North Dakota	1	1	0
Ohio	44	53	35
Oklahoma	11	8	7
Oregon	13	8	6
Pennsylvania	28	32	34
Rhode Island	0	0	0
South Carolina	4	4	1
South Dakota	0	1	0
Tennessee	21	20	13
Texas	21	30	39
Utah	7	5	4
Vermont	0	0	0
Virginia	8	10	7
Washington	21	20	17
West Virginia	3	4	2
Wisconsin	10	9	3
Wyoming	1	1	0
Puerto Rico	1	1	0

SOURCE: American College of Surgeons, 1989 Socio-Economic Factbook for Surgery.

Chapter 3

PUBLIC HEALTH CARE COVERAGE—EXPENDITURES AND ENROLLMENT

◆ Federal, State and Local Health Care Programs

In 1988, all levels of government combined spent $227.5 billion to fund medical and health care services, research and medical facility construction. The government share represented 42.1 percent of total national health expenditures.

Public expenditures increased by 9.2 percent between 1987 and 1988, compared to 10.3 percent for total public and private expenditures. Per capita government expenditures were $895.

National Health Expenditures in Billions (selected calendar years 1970–1988)

	1970	1975	1980	1985	1986	1987	1988
National health expenditures	$74.4	$132.9	$249.1	$420.1	$450.5	$488.8	$539.9
Private	46.7	77.8	143.9	245.2	259.8	280.5	312.4
Public	27.7	55.1	105.2	174.9	190.7	208.3	227.5
Federal	17.7	36.4	72.0	123.4	132.8	144.0	157.8
State/local	9.9	18.7	33.2	51.5	57.9	64.3	69.63

SOURCE: U. S. Department of Health and Human Services, Health Care Financing Administration.

◆ Federal Programs

Prior to 1967, federal health expenditures were less than half of total government expenditures for health care. By 1988, federal expenditures for health care were almost 20 percent of the total.

The majority of federal health spending is for health services provided to six major groups: low-income individuals and others eligible for Medicaid, those over age 65 (Medicare), military personnel and their dependents, veterans, federal civilian employees and native Americans.

Medicare

Medicare, effective since July 1, 1966, is a federally administered program that provides hospital and medical insurance protection to those persons aged 65 and older, disabled persons under age 65 who receive cash benefits under Social Security or Railroad Retirement programs and people of all ages with chronic kidney disease. Since 1973 aliens and some federal civil service employees and annuitants have been eligible to enroll by paying a monthly premium.

Many aged or disabled members who are covered by Medicare also are covered by Medicaid. Where this dual coverage exists, most state Medicaid programs pay the Medicare premiums, deductibles and copayments and in some cases for services not covered by Medicare.

Medicare consists of two parts: compulsory hospitalization insurance (HI) called Part A and voluntary supplementary medical insurance (SMI) called Part B, which supplements payment for physicians' services, medical services and supplies not covered under Part A. Part A is financed by contributions from employers, employees and participants; Part B is voluntary and is financed by monthly premiums paid by those who enroll and by the federal government.

On January 1, 1990, Medicare's Part A deductible rose from $560 to $592. The monthly Part B premium increased from $27.90 to $28.60. Insurance companies, Blue Cross-Blue Shield plans and several other independent organizations serve as fiscal intermediaries for the government. More than 6,500 hospitals have an agreement to participate under the Medicare prospective payment system (PPS). Exceptions are psychiatric, children's, long-term care and rehabilitation hospitals and medical facilities that have an approved waiver.

During the 20 years between 1968 and 1988, enrollment in the Medicare program has increased from 20 million to almost 33 million people. An increase in this country's population and longer life expectancies contributed to the total enrollment in 1988 of 14 million males and 19 million females.

White enrollees numbered 28.1 million and 4.3 million were of other racial origins.

More than $85 billion was paid by the federal government on behalf of Medicare enrollees in 1988.

Projections by the Health Care Financing Administration (HCFA) indicate that by 2050 there will be 69 million people aged 65 years or over who will be eligible for Medicare. Of this number 15 million will be age 85 or more.

Medicaid

This federal-state program of medical assistance helps certain low-income individuals and families.

Administered by each state according to designated federal requirements and guidelines, the program is financed from both state and federal funds. It provides medical assistance to persons who are eligible for such cash assistance programs as Aid to Families of Dependent Children (AFDC) and Supplemental Security Income (SSI). Medicaid benefits also may be available to other persons who have enough income for basic living expenses but cannot afford to pay for their medical care.

To qualify for federal matching funds, the law requires state programs to include inpatient and outpatient hospital services, laboratory and X-ray services and skilled nursing and home health services for individuals aged 21 and older. Services such as periodic screening, diagnosis and treatment, family planning for children under age 21 and physicians' services also must be provided. Participation in the Medicaid program is optional but currently all states participate.

As indicated in Table 3.2, the Medicaid program paid $48.7 billion for services provided to 23 million recipients in 1988, $3.4 billion less than the program paid for approximately the same number of people in 1987.

Utilization of Medicare and Medicaid Services

According to a recent report from HCFA, an estimated 55 million Americans received services paid for by Medicare or Medicaid in 1988. One out of five beneficiaries (9 million) used inpatient hospital services, 42 million received reimbursable physician services, 29 million were paid for outpatient visits and more than 800,000 received benefits for care in skilled nursing facilities. Medicaid provided 13 million people with prescription drugs and a combination of Medicare and Medicaid benefits provided services to 2.5 million recipients of home health care.

◆ Other Government Services

Military Personnel and Dependents

Medical treatment at any Department of Defense installation medical facility is available to all active and retired military personnel and their dependents. A program called the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is designed for military families unable to use government medical facilities because of distance, overcrowding or unavailability of appropriate medical treament. It provides payment (after a deductible amount) for medical care. Retired military personnel and their dependents and dependents of deceased personnel are compensated by CHAMPUS if they are not eligible for Medicare.

CHAMPUS spent $2.8 billion for medical care out of the $13 billion budgeted by the Department of Defense in 1989.

Federal Civilian Employees

A variety of insurance programs are available to civilian employees who work for the federal government. Premiums are paid biweekly by the employing agency and the employee. In 1988, 4 million active and retired federal civilian employees and their dependents were enrolled in these programs.

In addition to federal payment of the employer contributions under these programs, the government also incurs administrative expenses for the operation of on-site health care facilities for federal civilian employees.

In fiscal 1988, civilian health programs cost the government nearly $6.1 billion.

Veterans' Medical Care

The government budgeted $234.7 million for Veterans Administration medical research in 1989. In addition, the Veterans Administration operates 170 medical centers for the care of individuals who served honorably in the armed forces. Patients with service-related ailments receive top priority.

Indian Health Services

More than $1.2 billion in federal funds was appropriated in 1989 to provide medical care and health services for 1 million American Indians and Alaskan natives.

♦ State and Local Programs

The public health programs of state health agencies and local health departments can be divided into four primary program areas: personal health, environmental health, health resources and laboratory services. In addition to these primary programs, the agencies also perform general administrative and service functions. Not all state health agencies perform the same services. In some states, designated expenditures for mental health care may be controlled by a separate mental health agency.

During fiscal year 1987 (the latest year for which data are available), 55 state health agencies spent a total of $10.3 billion for their public health programs (excluding Medicaid), which was distributed as follows: personal health, $6.9 billion; environmental health, $733 million; health resources, $758 million; laboratory, $299 million; and general administration, $602 million. (Table 3.5)

The bulk of state health agencies' expenditures for 1987 were for maternal and child health, communicable diseases, handicapped children, dental health, chronic disease, mental health, state health agency-operated institutions, home health care and services to special population groups (i.e., immigrants and refugees).

There were nearly 3,000 local health departments in 1987. U.S. territories and possessions (except Puerto Rico and American Samoa), three states and the District of Columbia do not have local health departments.

Table 3.1

Medicare Enrollments and Payments (Millions)

Year	Hospital and/or medical insurance Part A + B: Number of enrolled persons	Hospital and/or medical insurance Part A + B: Benefit payments	Hospital insurance Part A: Number of enrolled persons	Hospital insurance Part A: Benefit payments	Supplementary medical insurance Part B: Number of enrolled persons	Supplementary medical insurance Part B: Benefit payments
All enrollees						
1967	19.5	$ 3.1	19.5	$ 2.5	17.9	$ 0.7
1968	19.8	5.1	19.8	3.7	18.8	1.4
1969	20.1	6.3	10.0	4.7	19.2	1.6
1970	20.5	6.8	20.4	4.8	19.6	1.9
1971	20.9	7.5	20.7	5.4	19.9	2.1
1972	21.3	8.4	21.1	6.1	20.4	2.3
1973	23.5	9.0	23.3	6.6	22.5	2.4
1974	24.2	10.7	23.9	7.8	23.2	2.9
1975	25.0	14.1	24.6	10.4	23.9	2.8
1976	25.7	16.9	25.3	12.2	24.6	4.7
1977	26.5	20.8	26.1	14.9	25.4	5.9
1978	27.1	24.3	26.8	17.4	26.1	6.9
1979	27.9	28.1	27.5	19.9	26.8	8.3
1980	28.5	33.9	28.1	23.8	27.4	10.1
1981	29.1	41.2	28.6	28.9	27.9	12.3
1982	29.5	49.2	29.1	34.3	28.4	14.8
1983	30.1	55.6	29.6	38.1	28.9	17.5
1984	30.5	60.9	30.0	41.5	29.4	19.5
1985	31.1	69.5	30.6	47.7	29.9	21.8
1986	31.8	74.1	31.2	48.9	30.6	25.2
1987	32.4	79.8	31.9	49.8	31.2	29.9
1988	32.9	85.5	32.4	51.9	31.6	33.7
Aged 65 and more						
1967	19.5	$ 3.2	19.5	$ 2.5	17.9	$ 0.7
1968	19.8	5.1	19.7	3.7	18.8	1.3
1969	20.1	6.3	20.1	4.7	19.2	1.6
1970	20.5	6.8	20.4	4.8	19.6	1.9
1971	20.9	7.4	20.7	5.4	19.9	2.1
1972	21.3	8.3	21.2	6.1	20.4	2.3
1973	21.8	9.0	21.6	6.6	20.9	2.4
1974	22.3	9.6	21.9	7.1	21.4	2.5
1975	22.8	12.7	22.5	9.4	21.9	3.3
1976	23.3	15.1	22.9	11.0	22.4	4.0
1977	23.8	18.3	23.5	13.3	22.9	5.0
1978	24.4	21.2	23.9	15.4	23.5	5.8
1979	24.9	24.4	24.6	17.5	24.1	6.9
1980	25.5	29.4	25.1	20.9	24.7	8.5
1981	26.1	35.9	25.6	25.5	25.2	10.4
1982	26.5	42.6	26.1	30.2	25.7	12.4
1983	27.1	48.4	26.7	33.6	26.3	14.8
1984	27.6	53.6	27.1	36.8	26.8	16.8
1985	28.2	61.5	27.7	42.4	27.3	19.1
1986	28.8	65.4	28.3	43.4	27.9	22.1
1987	29.4	70.7	28.8	44.4	28.3	26.4
1988	29.9	76.1	29.3	46.4	28.8	29.8

NOTE: Detail may not add due to rounding.

SOURCE: U.S.Department of Health and Human Services, Health Care Financing Administration, Bureau of Data Management and Strategy.

Table 3.2

Medicaid Recipients and Benefits Paid by Federal and State Governments (Millions)

Fiscal year	Annual recipients	Total annual benefits paid	Age 65 and more		Dependent children		All others	
			Annual recipients	Annual benefits paid	Annual recipients	Annual benefits paid	Annual recipients	Annual benefits paid
1972	19.6	$ 6.3	3.3	$ 1.9	11.1	$ 2.1	2.3	$ 2.3
1973	19.6	8.7	3.5	3.2	12.7	2.9	3.4	2.5
1974	21.5	9.9	3.7	3.7	13.9	3.4	3.9	2.9
1975	22.0	12.2	3.6	4.4	14.1	4.2	4.3	3.6
1976	22.8	14.1	3.6	4.9	14.7	4.7	4.5	4.5
1977	22.8	16.2	3.6	5.5	14.4	5.2	4.8	5.5
1978	22.0	17.9	3.4	6.3	14.1	5.4	4.6	6.3
1979	21.5	20.5	3.4	7.1	13.7	5.9	4.5	7.5
1980	21.6	23.3	3.4	8.7	14.2	6.3	4.4	8.2
1981	22.0	27.2	3.4	9.9	14.8	7.3	4.4	10.1
1982	21.6	29.4	3.2	10.7	14.9	7.6	4.3	11.1
1983	21.6	32.4	3.4	11.9	15.1	8.3	4.1	12.1
1984	21.6	33.9	3.2	12.8	15.3	8.4	4.1	12.7
1985	21.8	37.5	3.1	14.1	15.3	9.2	3.4	14.3
1986	22.5	41.1	3.1	15.1	15.7	10.1	3.7	15.9
1987	23.2	52.1	3.3	16.1	15.8	11.1	4.1	17.8
1988	22.9	48.7	3.2	17.1	15.5	11.7	4.2	19.8

NOTES: Data excludes territories and possessions. Detail may not add to totals due to rounding. Excludes premium and per capita amounts and state expenditures not eligible for federal matching funds.

SOURCE: U.S Department of Health and Human Services, Health Care Financing Administration, Medicaid Statistics Branch.

Table 3.3

Medicare and Medicaid Benefits, Medicare Enrollments and Medicaid Recipients by State and Territory (1988) (Millions of dollars, thousands of persons)

	Medicare		Medicaid	
States and territories	Benefits paid	Number of persons enrolled	Benefits paid	Unduplicated count of recipients
Total	**$85,704**	**32,980**	**$48,710**	**22,906**
Alabama	1,437	563	444	305
Alaska	56	22	95	33
Arizona	1,171	462	NA	NA
Arkansas	869	381	432	227
California	9,631	3,152	5,225	3,674
Colorado	727	334	436	180
Connecticut	1,147	456	837	2,213
Delaware	212	84	101	37
District of Columbia	322	78	360	97
Florida	5,965	2,201	1,493	768
Georgia	1,753	699	1,105	537
Hawaii	222	118	154	91
Idaho	260	126	123	46
Illinois	4,304	1,500	1,857	1,043
Indiana	1,716	737	1,036	301
Iowa	989	449	472	228
Kansas	839	355	338	170
Kentucky	1,208	518	689	413
Louisiana	1,477	513	775	432
Maine	384	178	324	120
Maryland	1,580	517	843	320
Massachusetts	2,394	850	2,043	556
Michigan	3,505	1,190	1,806	1,104
Minnesota	920	573	1,098	336
Mississippi	818	357	414	366
Missouri	2,029	761	687	379
Montana	244	113	136	81
Nebraska	450	233	227	105
Nevada	299	121	95	36
New Hampshire	290	132	166	33
New Jersey	2,972	1,066	1,718	533
New Mexico	345	167	217	105
New York	7,505	2,480	9,209	2,212
North Carolina	1,692	843	957	411
North Dakota	241	97	161	44
Ohio	4,199	1,491	2,359	1,117
Oklahoma	1,048	437	582	245
Oregon	798	403	331	189
Pennsylvania	5,797	1,902	2,250	1,086
Rhode Island	373	155	332	98
South Carolina	831	418	455	263
South Dakota	229	108	124	41
Tennessee	1,673	665	890	479
Texas	4,556	1,732	1,944	1,062
Utah	311	149	185	86
Vermont	143	72	113	51

Continued

Virginia	1,618	686	756	326
Washington	1,310	584	852	403
West Virginia	667	300	284	221
Wisconsin	1,607	695	985	403
Wyoming	118	49	33	20
U.S. territories and possessions	366	432	131	1,278
Foreign countries	28	260	NA	NA

NOTE: Detail may not add to totals due to rounding and distributions by state are estimated.
SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration.

Table 3.4

Hospital and Medical Expenditures under Worker's Compensation (Millions)

Year	Total	State and local	Federal
1965	$ 799	$ 787	$ 12
1966	910	897	13
1967	1,012	996	15
1968	1,147	1,130	17
1969	1,263	1,244	19
1970	1,409	1,384	25
1971	1,441	1,414	27
1972	1,575	1,545	30
1973	1,884	1,848	35
1974	2,176	2,133	43
1975	2,436	2,371	61
1976	2,758	2,685	73
1977	3,191	3,112	79
1978	3,682	3,585	97
1979	4,541	4,424	117
1980	5,151	5,012	140
1981	5,695	5,536	159
1982	4,500	4,600	200
1983	5,400	5,100	300
1984	6,100	5,800	300
1985	7,000	6,700	300
1986	7,800	7,500	300
1987	8,900	8,600	300
1988	9,968	9,668	300

NOTE: For 1970 and succeeding years data include federal "black lung" benefits. Detail may not add to totals due to rounding.
SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration.

Table 3.5

Expenditures of State Health Agencies (SHA) and Local Health Departments (LHD) by Program Area (1988)

States and territories	Total public health expenditures	Direct SHA expenditures	SHA Inter-governmental transfers to LHDs	Additional expenditures of LHDs
Total	$10,567,818	$6,588,870	$1,724,058	$2,254,890
Alabama	135,021	82,463	8,101	44,456
Alaska	29,403	28,015	1,388	**
Arizona	368,390	136,456	8,963	222,970
Arkansas	67,265	678,265	**	**
California	792,670	353,327	439,343	**
Colorado	132,737	104,839	4,260	23,637
Connecticut	94,496	64,539	8,444	21,513
Delaware	52,806	52,806	**	**
District of Columbia	116,534	116,534	**	**
Florida	366,796	150,395	216,402	**
Georgia	239,924	148,552	50,293	41,078
Hawaii	218,562	211,534	6,582	445
Idaho	21,005	17,831	3,174	**
Illinois	346,436	148,646	40,687	157,104
Indiana	139,937	98,017	8,221	33,700
Iowa	76,512	53,018	5,255	18,239
Kansas	62,380	38,560	8,386	15,435
Kentucky	154,857	76,179	34,053	44,625
Louisiana	116,726	116,042	685	**
Maine	25,736	25,736	**	**
Maryland	732,553	633,012	99,542	**
Massachusetts	281,759	279,362	2,396	**
Michigan	469,589	182,511	124,128	162,949
Minnesota	193,852	65,315	22,139	106,398
Mississippi	105,899	75,856	30,043	**
Missouri	172,506	68,028	40,796	63,681
Montana	*	*	*	*
Nebraska	27,675	26,984	690	**
Nevada	33,195	18,467	1,583	13,145
New Hampshire	23,024	22,967	57	**
New Jersey	270,103	180,460	15,775	73,868
New Mexico	59,152	58,221	**	932
New York	972,094	600,922	94,843	276,328
North Carolina	286,642	128,125	50,747	107,770
North Dakota	24,263	14,523	2,964	6,776
Ohio	298,350	150,402	32,564	115,384
Oklahoma	102,378	53,253	35,081	14,043
Oregon	40,081	30,961	9,220	**
Pennsylvania	301,851	235,973	29,974	35,903
Rhode Island	35,615	35,615	**	**
South Carolina	181,959	105,038	76,891	**
South Dakota	20,688	20,688	**	**
Tennessee	220,633	158,877	19,720	42,036
Texas	526,817	329,399	33,315	164,102
Utah	74,047	40,600	17,412	16,035
Vermont	21,665	21,665	**	**
Virginia	206,196	96,111	110,084	**
Washington	112,056	19,312	6,674	86,069

Continued

West Virginia	172,664	153,192	6,528	12,944
Wisconsin	75,585	62,242	13,342	**
Wyoming	13,895	13,895	**	**
American Samoa	*	*	**	**
Guam	7,608	7,608	**	**
Puerto Rico	*	*	*	*
Virgin Islands	*	*	**	**

*Estimated
**No data or data unobtainable

SOURCE: Public Health Foundation, Public Health Agencies 1990: An Inventory of Programs and Block Grant Expenditures.

Chapter 4

MEDICAL CARE COSTS

◆ National Health Expenditures (NHE)

Total health care spending, represented by national health expenditures, includes both private and public expenditures for personal health care, medical research, construction of medical facilities, administrative and insurance costs and government-sponsored public health programs.

National health spending reached $539.9 billion in 1988, a 10.5 percent increase over 1987, compared to 8.5 percent the previous year. Public spending amounted to 42.1 percent of all health care costs in 1988.

In 1960, NHE constituted 5.3 percent of the gross national product (GNP) and has increased steadily over the years, reaching 11.1 percent in 1988. (Table 4.3)

Hospital care, totaling $211.8 billion in 1988, continued to represent the largest share of personal health spending (44.3 percent). The cost of physicians' services was the next highest at $105.1 billion. (Table 4.1)

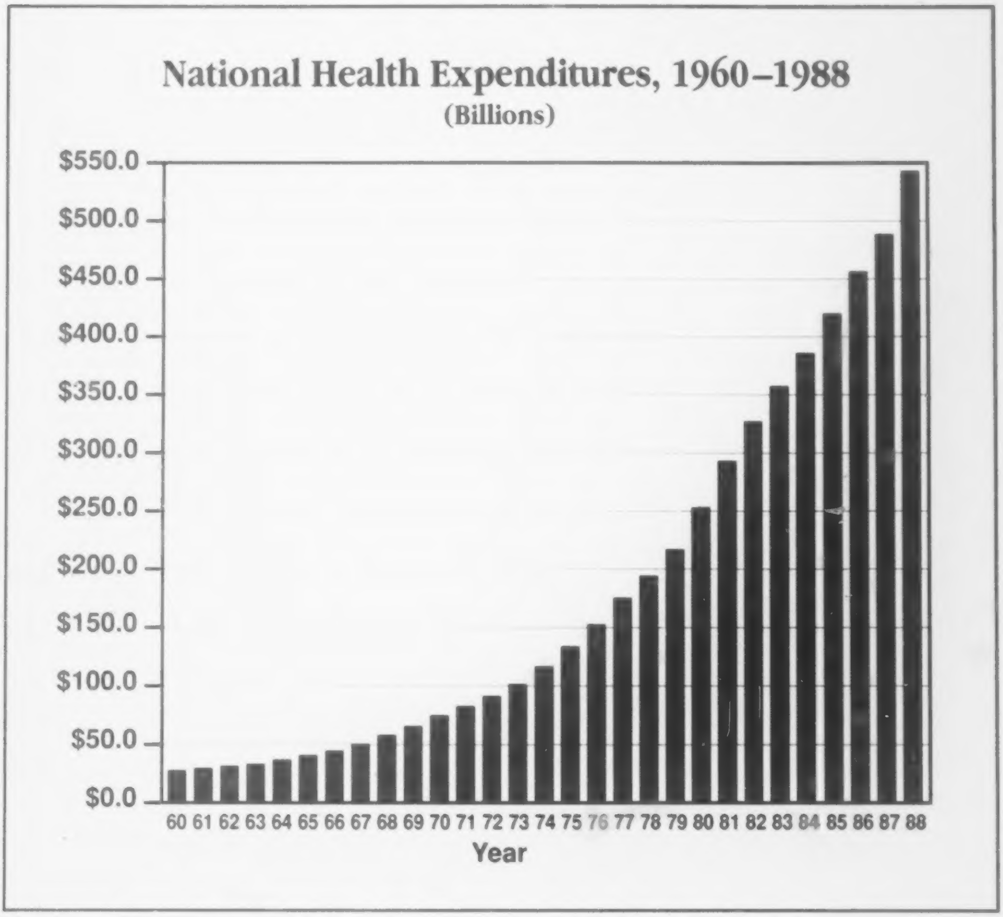
According to the HCFA, U.S. nursing home care in 1988 cost $43.1 billion. Medicare contributed only $800 billion to this total. Medicaid paid nearly half ($19.3 billion) of these expenses, making it a de facto long-term care financing program. The remaining cost of financing long-term care fell almost exclusively on the patients and their families ($23.2 billion). Private long-term care insurance, still in its infancy, paid only $500 million.

HCFA projects that the NHE will reach $647.3 billion in 1990.

Personal Health Care Expenditures

The personal health care expenditures (PHCE) figure, which accounts for 88.6 percent of the NHE, represents private and public spending for direct health and medical services to individuals.

Personal health care figures include expenditures for consumers, whether insured or not. Included are expenses for nonprescribed drugs and medicines, household supplies and other items not covered by insurance.



National Health Expenditures, 1960–1988
(Billions)

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration.

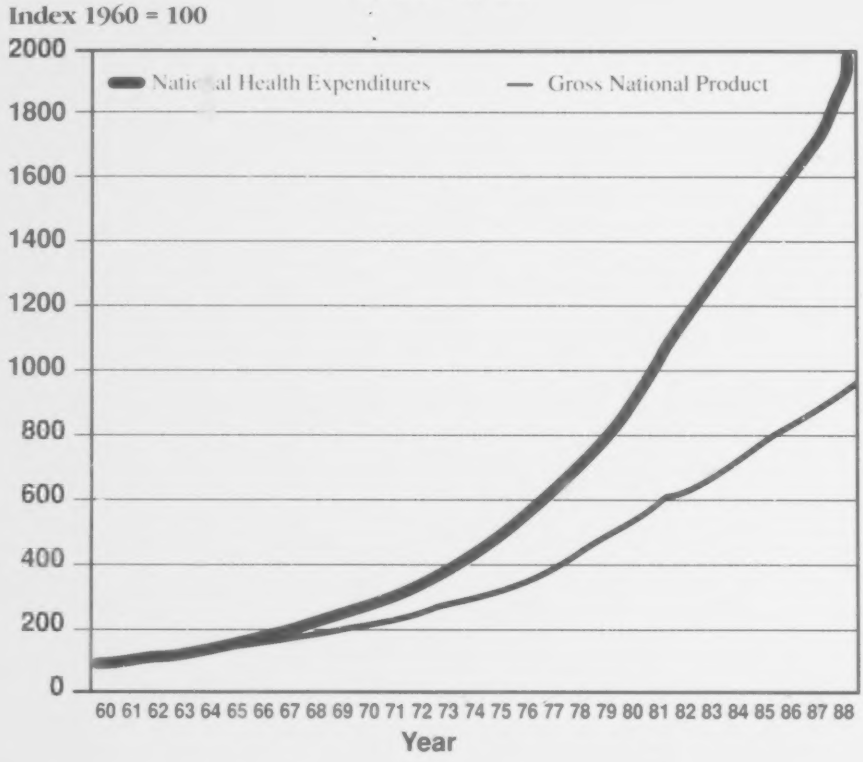
Factors Affecting Growth of Personal Health Care Expenditures
(12-month period ending December)

	1981	1982	1983	1984	1985	1986	1987	1988
All Factors	100%	100%	100%	100%	100%	100%	100%	100%
Prices	67	69	67	73	61	52	52	67
Population	7	9	10	12	11	11	9	10
Intensity	26	22	23	15	28	37	39	23

SOURCE: U. S. Department of Health and Human Services, Health Care Financing Administration.

Spending for personal health care in the nation amounted to $478.3 billion in 1988. (Table 4.4) Included in this figure are expenditures for hospital care, professional services, drugs and medical sundries and nursing home care. Not included are expenditures for medical research, construction of medical facili-

Growth of National Health Expenditures and GNP, 1960–1988



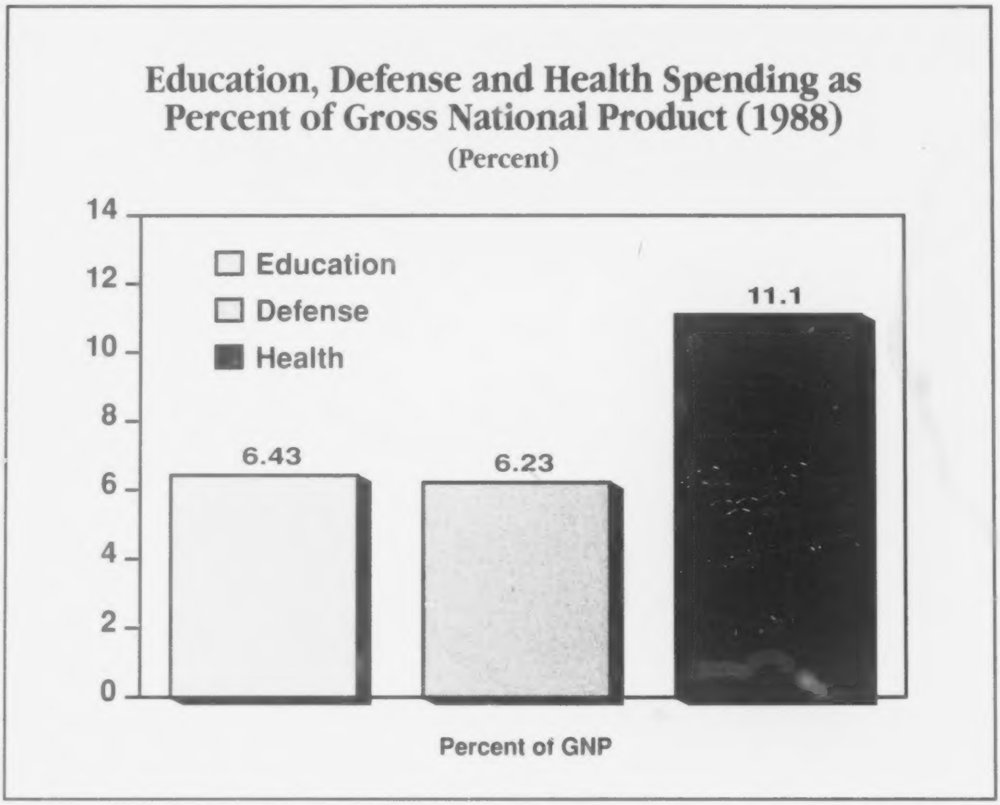
SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration.

ties, public health activities such as disease prevention and control and the net cost of health insurance. These items are included in the NHE figure.

Table 4.2 shows the per capita amounts of personal expenditures. Per capita expenditure was $2,124 in 1988, 9 percent more than the 1987 figure of $1,941. By 1990 per capita expenditure is expected to reach $2,511.

The largest portion (76.3 percent) of the personal health care dollar is financed by third-party sources. Private health insurance, philanthropy, industry and the government paid $365.5 billion of all expenditures for personal health care in 1988.

Personal Consumption Expenditures. Personal consumption expenditures (PCE) is a measure of health expenditure published by the Department of Commerce rather than by HCFA. It measures private medical care payments. Monies from three government programs (Medicare, Worker's Compensation and Temporary Disability Insurance) are treated as transfer payments and are



Education, Defense and Health Spending as Percent of Gross National Product (1988)
(Percent)

SOURCE: U.S. Department of Commerce.

included. PCE and PHCE differ because different accounting practices are used for each.

PHCE for 1989 was $452.8 billion, which represents 13.1 percent of the total spent by Americans on all personal needs, compared to 10.3 percent a decade earlier. As a proportion of the public's disposable income, these expenditures were 11.7 percent in 1989, down from 12.7 percent in 1988. (Table 4.4)

Consumer Price Index

The consumer price index (CPI) is a measure of the average change in the prices paid by urban consumers for a fixed market basket of consumption goods and services ranging from McIntosh apples to Apple Macintosh computers.

The CPI compares what the market basket of goods and services costs consumers this month with what the same market basket cost a month, a year or even 10 years ago.

According to the 1989 CPI, medical prices increased by 7.7 percent from 1988, compared to a 4.8 percent increase for all items. (Table 4.8)

Individual components of the medical care index have differed in their rates of increase, but hospital room rates have risen most rapidly.

Hospital Statistics

Community Hospital Statistics. In 1988, the average cost for treating a patient in a community hospital was $586.33 per inpatient day, almost a 9 percent increase over 1987. On a state-by-state basis, the average cost per inpatient day in 1988 varied considerably from a low of $359.76 in South Dakota to a high of $961.32 in Alaska.

In 1988, the average length of time a patient remained in a community hospital was 7.2 days, the same as one year earlier.

The average length of stay varied by area, from a low of 5.5 days in Oregon to a high of 10.5 in North Dakota. The average cost of a stay in a community hospital in 1988 was $4,206.73, a 9 percent increase over 1987.

Operating costs of community hospitals were $169 billion in 1988, which is a 10.5 percent increase over the $153 billion spent in 1988. The American Hospital Association (AHA) reports that labor costs reached $74 billion in 1988, representing 44 percent of community hospital expenditures.

During the past decade, hospitals have broadened the range of alternative services they offer. These changes reflect advances in technology, a greater emphasis on nonacute care in new payment systems and medical care which allows a greater choice for the patient.

Psychiatric Hospital Statistics. The nation's 726 nonfederal mental hospitals were 87 percent occupied in 1988, with an increase in admissions of 18.6 percent between 1978 and 1988. There was a sharp decline in the average length of stay, from 119 days in 1987 to 75 days in 1988. Psychiatric hospitals have increased in number (200 in the past 10 years), and admissions rose almost 19 percent during the 10-year period. According to *Hospital Statistics*, it cost almost $11 billion to operate facilities devoted to mental health care in the United States in 1988.

Semiprivate Room Charges. A continuing survey conducted by HIAA shows that as of January 1990, the national average room and board charge to the patient for a semiprivate room was $297 per day, a 12.5 percent increase over January 1989. (Table 4.11) Survey results are based on responses from 1,414 nongovernmental short-term general hospitals nationwide. The highest daily average rate ($418) was in the District of Columbia. The lowest rate was in Puerto Rico ($158 per day).

Professional Fees

Surgical Charges. Surgical charges vary considerably by geographic region and by metropolitan and nonmetropolitan areas. Table 4.12, containing data from a 1989 survey by *Medical Economics*, shows fees for a number of common surgical procedures and emergency medical procedures across the United States.

The Division of Health Care Statistics of the National Center for Health Statistics (NCHS) listed the 10 most frequently performed surgical procedures in 1987 as follows:

Procedure	Number in thousands
Biopsy	1,378
Cesarean section	953
Repair OB (birth) laceration	660
Hysterectomy	655
Operations on spinal cord and spinal canal	588
Excision of skin lesions	568
Arthroplasty of joints	556
Cholecystectomy	536
Oophorectomy and salpingo-oophorectomy	490
Open reduction of fracture	481

The 1989 HIAA Prevailing Healthcare Charges System collects data on charges by geographic areas of the United States. Charges for selected surgical procedures for 1989 are shown below:

Procedure	New York City	Philadelphia	Atlanta	Chicago	Dallas	Los Angeles
Excision of breast lesion (lumpectomy)	$1,162	$ 521	$ 551	$ 546	$ 539	$ 680
Cesarean section	3,669	1,626	1,547	1,837	1,375	1,430
Hysterectomy	4,165	2,207	1,885	2,348	1,744	2,246
Oophorectomy	2,518	1,683	1,079	1,280	947	1,224
Salpingo-oophorectomy	3,211	1,669	1,063	1,354	1,140	1,414
Coronary bypass (triple)	8,069	5,624	4,071	5,766	4,425	4,900
Appendectomy	1,815	909	860	1,036	870	1,189
Cholecystectomy	2,521	1,351	1,197	1,502	1,260	1,631
Vasectomy	601	423	352	418	329	440

NOTE: Health Insurance Association of America's Surgical Prevailing Healthcare Charges System is copyrighted and is available by subscription only to certain types of organizations.

Physicians' Fees. Physicians' fees vary considerably by type of practice or specialty, type of visit and region of the United States. (Table 4.13) In 1989, the median charges for an initial office visit and an office revisit were highest for specialists and for physicians practicing in the western states. According to a continuing survey done by *Medical Economics*, physicians' fees historically have risen at a higher rate than the CPI. The all-services index of the CPI increased by 4.8 percent in 1989, while physicians' fees rose almost 10 percent.

♦ The Cost of Mental Illness and Drug Abuse

Mental illness and drug abuse in the United States cost an estimated $73 billion each year, which represents approximately 14 percent of the NHE ($539.9 billion) for 1988.

In 1988, nearly 4 million adult Americans between the ages of 25 and 44 were beset with some form of mental disorder. (Table 4.15) In a survey of their claimants, Mutual of Omaha Insurance Company reported that 350 out of every 1,000 people visited a psychiatrist or psychologist in 1989, paying an average of $72 per visit. (Table 4.16)

According to the National Mental Health Association, 63.8 percent of people with diagnosable mental disorders receive some ambulatory medical treatment, 18 percent actually visit a mental health specialist and 8.6 percent consult a general family practitioner.

More than 70 percent of recorded psychiatric admissions in 1989 were actually readmissions.

In a 1989 survey of employers, HIAA found that conventional, PPO and HMO plans provide benefits for outpatient and inpatient mental health treatment, drug treatment and alcohol treatment for the majority of employees.

♦ The Cost of Having a Baby

Most group medical expense plans provide maternity care. Maternity coverage is often mandated by state law, and more than 95 percent of employees under employer-sponsored group policies underwritten by commercial insurance companies have maternity benefits.

In 1989, HIAA conducted a national survey to determine the costs of normal and cesarean births across the United States. The average cost of a vaginal delivery in a hospital delivery room was found to be $4,334. The Midwest reported the lowest cost of $4,149 and the Northeast reported the highest charge of $4,456. (Table 4.14)

The number of cesarean deliveries increased from 17 percent of all births in 1980 to 25 percent in 1989. Cesarean births have remained at almost 4 percent of the total surgical procedures ever since. The average cost of an uncomplicated cesarean delivery in the United States was $7,186 in 1989.

◆ Medical Costs Resulting from Accidents

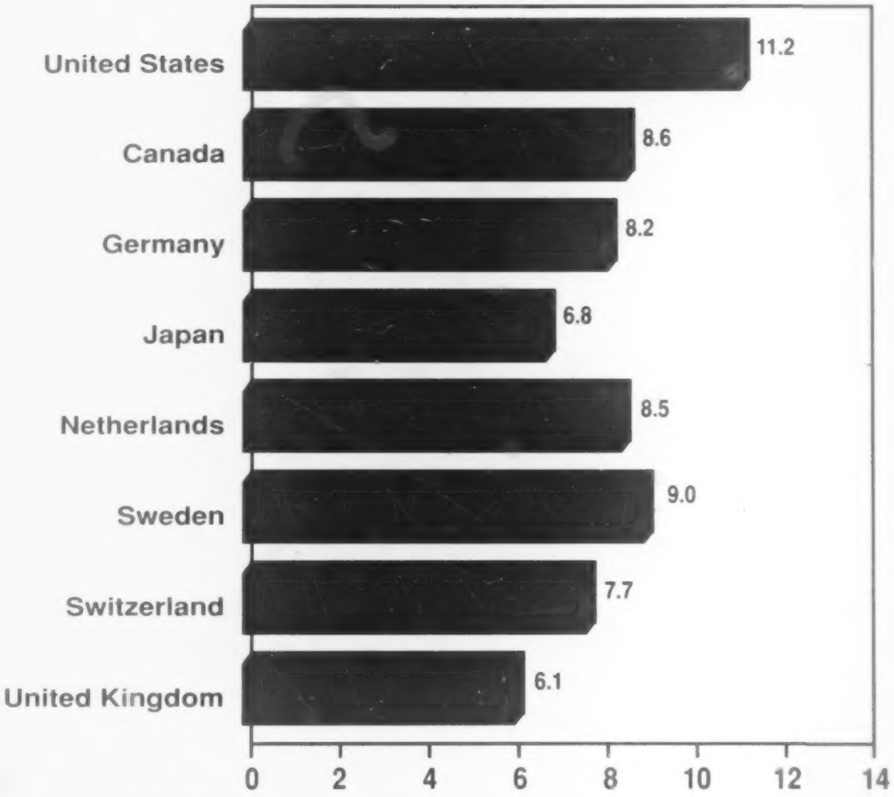
The economic losses that result from various types of accidents are shown in Table 4.19. Medical expense costs incurred through accidents totaled $133.2 billion in 1988.

◆ International Health Care Expenditure

According to the Organization for Economic Cooperation and Development (OECD), the United States allocates a greater proportion of its resources to health care than any other country. The United States spends 11.2 percent of gross domestic product (GDP), Canada and Sweden are next with 8.6 percent and 9 percent. (GDP differs from GNP in that it does not include net foreign investment income.)

Health Expenditures as Percent of Gross Domestic Product (1987)

(Percent of gross domestic product)



U.S. costs for medical procedures and per hospital bed, day and stay are the highest in the world.

SOURCE: Organization for Economic Cooperation and Development.

Table 4.1

National Health Expenditures by Type of Expenditure and Source of Funds (1987–1988) (Billions)

		Private					Government		
			Consumer						
Year and type of expenditure	**Total all sources**	**All private funds**	**Total**	**Out of pocket**	**Private insurance**	**Other**	**Total**	**Federal**	**State and local**
1987									
National health expenditures	$488.8	$280.5	$258.7	$102.4	$156.2	$21.8	$208.3	$144.0	$64.3
Health services and supplies	471.6	273.8	258.7	102.4	156.2	15.2	197.8	135.9	61.9
Personal health care	434.7	256.9	242.3	102.4	139.8	14.7	177.8	130.9	46.9
Hospital care	193.7	87.5	78.1	8.7	69.3	9.4	106.2	80.4	25.8
Physicians' services	93.0	61.8	61.8	17.8	43.9	0.0	31.2	25.2	6.0
Dentists' services	27.1	26.4	26.4	15.4	11.0	—	0.7	0.4	0.3
Other professional services	20.2	16.0	13.6	6.5	7.0	2.4	4.1	3.2	1.0
Home health care	4.2	1.1	0.8	0.5	0.3	0.3	3.1	2.4	0.7
Drugs and other medical nondurables	38.6	34.5	34.5	27.5	6.9	—	4.2	2.0	2.2
Vision products and other medical durables	9.8	7.8	7.8	6.9	0.9	—	2.0	1.3	0.2
Nursing home care	39.7	20.2	19.4	19.0	0.4	0.8	19.5	11.4	8.2
Other personal health care	8.4	1.7	—	—	—	1.7	6.7	4.2	2.5
Program administration and net cost of private health insurance	22.4	16.9	16.4	—	16.4	0.5	5.5	3.4	2.1
Government public health activities	14.5	—	—	—	—	—	14.5	1.6	12.9
Research and construction	17.2	6.7	—	—	—	6.7	10.5	8.1	2.4
Research	9.0	0.7	—	—	—	0.7	8.2	7.0	1.2
Construction	8.2	5.9	—	—	—	5.9	2.3	1.1	1.3
1988									
National health expenditures	$539.9	$312.4	$288.1	$113.2	$174.9	$24.3	$227.5	$157.8	$69.6
Health services and supplies	520.5	304.6	288.1	113.2	174.9	16.5	215.9	149.0	66.9
Personal health care	478.3	284.3	268.4	113.2	155.2	15.9	194.0	143.2	50.8
Hospital care	211.8	96.6	86.3	11.3	75.0	10.3	115.2	86.7	28.5
Physicians' services	105.1	70.0	69.9	19.9	50.0	0.0	35.2	28.7	6.4
Dentists' services	29.4	28.7	28.7	16.3	12.4	—	0.7	0.4	0.3
Other professional services	22.5	18.0	15.4	7.1	8.3	2.6	4.5	3.4	1.0
Home health care	4.4	1.1	0.8	0.5	0.3	0.3	3.3	2.6	0.7
Drugs and other medical nondurables	41.9	37.3	37.3	29.6	7.7	—	4.6	2.2	2.4
Vision products and other medical durables	10.8	8.6	8.6	7.6	1.0	—	2.3	2.0	0.2
Nursing home care	43.1	22.1	21.3	20.8	0.5	0.8	20.9	12.5	8.4
Other personal health care	9.3	1.9	—	—	—	1.9	7.4	4.7	2.7
Program administration and net cost of private health insurance	26.3	20.3	19.7	—	19.7	0.5	6.1	3.9	2.2

Continued

Government public health activities	15.9	—	—	—	—	—	15.9	1.9	14.0
Research and construction	19.4	7.8	—	—	—	7.8	11.5	8.8	2.7
Noncommercial Research	9.9	0.7	—	—	—	0.7	9.1	7.9	1.2
Construction	9.5	7.1	—	—	—	7.1	2.4	0.9	1.5

NOTES: Research and development expenditures of drug companies and other manufacturers and providers of medical equipment are excluded from noncommercial research, being implicitly included in the value of the good or service being produced. "Other private funds" include funding through philanthropy and nonpatient revenues, business spending for industrial in-plant health services, and privately financed construction.

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration, Office of the Actuary, Office of National Cost Estimates.

Table 4.2

National Health Expenditures in Aggregate, Per Capita, Percent Distribution and Percent Change by Source of Funds (1960–1988)

Item	1960	1965	1970	1975	1980	1985	1986	1987	1988
Billions									
National health expenditures	$ 27.1	$ 41.6	$ 74.4	$132.9	$ 249.1	$ 420.1	$ 450.5	$ 488.8	$ 539.9
Private	20.5	31.3	46.7	77.8	143.9	245.2	259.8	280.5	312.4
Public	6.7	10.3	27.7	55.1	105.2	174.9	190.7	208.3	227.5
Federal	2.9	4.8	17.7	36.4	72.0	123.4	132.8	144.0	157.8
State and local	3.7	5.5	9.9	18.7	33.2	51.5	57.9	64.3	69.6
Gross national product	515.0	705.0	1015.0	1598.0	2732.0	4015.0	4232.0	4524.0	4881.0
U.S. population (millions)	190.1	204.0	214.8	224.7	235.2	247.1	249.8	251.8	254.2
Per capita amounts (dollars)									
National health expenditures	$143.0	$204.0	$346.0	$592.0	$1059.0	$1700.0	$1806.0	$1941.0	$2124.0
Private	108.0	154.0	217.0	346.0	612.0	992.0	1041.0	1114.0	1229.0
Public	35.0	50.0	129.0	245.0	447.0	708.0	765.0	827.0	895.0
Federal	15.0	24.0	83.0	162.0	306.0	500.0	532.0	572.0	621.0
State and local	20.0	27.0	46.0	83.0	141.0	208.0	232.0	256.0	274.0
Percent distribution									
National health expenditures	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Private	75.5	75.3	62.8	58.5	57.8	58.4	57.7	57.4	57.9
Public	24.5	24.7	37.2	41.5	42.2	41.6	42.3	42.6	42.1
Federal	10.7	11.6	23.9	27.4	28.9	29.4	29.5	29.5	29.2
State and local	13.8	13.2	13.3	14.1	13.3	12.2	12.9	13.2	12.9
Percent of gross national product									
National health expenditures	5.3	5.9	7.3	8.3	9.1	10.5	10.6	10.8	11.1
Percent change by source of funds									
National health expenditures	NA	8.9	12.3	12.3	13.4	11.0	7.2	8.5	10.4
Private		8.9	8.3	10.7	13.1	11.2	6.0	8.0	11.4
Public		9.1	21.9	14.8	13.8	10.7	9.1	9.2	9.2
Federal		10.6	29.8	15.5	14.6	11.4	7.6	8.4	9.6
State and local		7.9	12.6	13.5	12.1	9.2	12.5	11.1	8.2
U.S. population		1.4	1.0	0.9	0.9	1.0	1.0	1.0	0.9
Gross national product		6.5	7.6	9.5	11.3	8.0	5.4	6.9	7.9

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration, Office of the Actuary.

Table 4.3

National Health Expenditures and Gross National Product (1950–1988)

	National health expenditures		Gross national product		
Year	Amount (billions)	Annual rate of growth (percent)	Amount (billions)	Annual rate of growth (percent)	National health expenditures as percent of GNP
1950	$ 12.7	12.2	$ 288.0	10.7	4.4
1955	17.7	7.0	406.0	7.0	4.4
1960	27.1	8.7	515.0	3.9	5.3
1961	29.1	7.1	534.0	3.6	5.4
1962	31.6	8.8	575.0	7.6	5.5
1963	34.4	8.9	607.0	5.6	5.7
1964	38.1	10.5	650.0	7.1	5.9
1965	41.6	9.4	705.0	8.5	5.9
1966	45.9	10.2	772.0	9.5	5.9
1967	51.7	12.6	816.0	5.8	6.3
1968	58.5	13.2	898.0	9.3	6.6
1969	65.7	12.4	964.0	7.9	6.8
1970	74.4	13.1	1016.0	5.4	7.3
1971	83.5	10.7	1103.0	8.6	7.5
1972	94.0	12.1	1213.0	10.0	7.6
1973	104.4	11.0	1659.0	12.1	7.5
1974	116.1	13.3	1473.0	8.3	7.9
1975	132.9	14.5	1598.0	8.5	8.3
1976	150.7	14.5	1783.0	11.5	8.5
1977	169.9	13.1	1991.0	11.7	8.6
1978	189.7	12.4	2250.0	13.0	8.6
1979	214.7	12.0	2508.0	11.5	8.6
1980	249.1	14.9	2732.0	8.9	9.1
1981	287.0	15.9	3053.0	11.7	9.5
1982	323.6	12.2	3166.0	3.7	10.2
1983	357.2	9.9	3406.0	7.6	10.5
1984	388.5	8.7	3772.0	10.7	10.3
1985	420.1	8.1	4015.0	6.4	10.5
1986	450.5	7.3	4232.0	5.4	10.6
1987	488.8	8.5	4516.0	6.7	10.8
1988	539.9	10.5	4874.0	7.9	11.1

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration and the U.S. Department of Commerce, Survey of Current Business, July 1989.

Table 4.4

Personal Health Care Expenditures by Source of Payment (1960–1988)

Year	Total personal health care expenditures	Consumer			Other private funds	State and local	Federal	Federal Medicare	Medicaid
		Consumer payments	Out of pocket	Private health insurance					
1960	$ 23.9	$ 18.4	$ 13.4	$ 5.1	$ 0.4	$ 2.9	$ 2.1	0.0	0.0
1961	25.3	19.4	13.7	5.7	0.5	3.2	2.3	0.0	0.0
1962	27.3	21.1	14.6	6.3	0.5	3.3	2.6	0.0	0.0
1963	29.8	22.8	15.9	6.9	0.5	3.7	2.8	0.0	0.0
1964	32.8	25.5	17.7	7.8	0.6	3.9	2.8	0.0	0.0
1965	35.6	27.7	19.0	8.7	0.8	4.3	2.9	0.0	0.0
1966	39.4	28.4	19.3	9.1	0.9	4.8	5.4	$ 1.6	$ 6.1
1967	44.7	28.5	18.9	9.6	1.0	5.5	9.7	4.9	1.5
1968	51.0	32.1	21.2	10.9	1.1	6.0	11.3	5.9	1.8
1969	57.1	35.9	23.1	12.9	1.5	6.7	13.1	6.8	2.2
1970	64.9	40.8	25.6	15.2	1.7	7.8	14.7	7.2	2.7
1971	71.3	44.1	27.1	17.0	1.9	8.5	16.9	8.1	3.7
1972	79.4	48.5	29.8	18.7	2.1	9.7	19.0	8.8	4.4
1973	88.6	54.1	32.9	21.2	2.5	11.2	21.1	10.2	4.7
1974	101.6	61.1	35.6	25.1	3.0	12.4	25.9	12.8	6.0
1975	116.6	68.4	38.5	29.9	3.5	14.4	30.9	15.7	7.1
1976	132.8	77.6	42.5	35.1	4.1	14.6	36.7	18.9	8.7
1977	149.2	87.1	46.3	40.8	4.7	16.8	41.2	22.1	9.4
1978	167.2	96.7	49.9	46.7	5.5	18.6	46.9	25.8	10.2
1979	188.6	108.2	53.5	54.7	6.5	20.9	53.8	30.1	11.9
1980	218.3	123.7	58.4	65.3	7.7	23.6	63.5	36.4	13.7
1981	253.2	142.6	65.5	77.1	8.9	26.7	74.9	43.9	16.3
1982	284.1	160.4	71.9	88.5	10.1	29.5	84.0	51.4	16.5
1983	312.4	176.2	78.8	97.4	11.0	31.8	93.4	58.4	18.2
1984	338.6	191.4	85.1	106.4	11.4	34.1	101.7	64.3	19.2
1985	367.1	205.8	92.7	114.2	12.9	[illegible]	111.6	70.1	21.9
1986	397.7	222.1	96.8	125.3	13.5	41.6	120.5	75.4	23.9
1987	434.7	242.3	102.4	139.8	14.6	46.9	130.9	81.7	26.4
1988	478.3	268.4	113.2	155.2	16.0	50.8	143.4	89.7	29.4

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration, unpublished data

Table 4.5

Personal Consumption Expenditures by Type of Expenditure (1985–1988) (Billions)

	1985	1986	1987	1988
Total expenditures	$2,629.9	$2,797.4	$3,010.8	$3,235.1
Food and tobacco	503.8	533.6	564.8	596.6
Housing	403.3	434.2	467.7	501.3
Medical care	327.5	357.6	399.3	443.0
Drugs and sundries	36.0	39.2	41.6	44.7
Physicians	73.5	80.6	93.8	105.0
Dentists	21.5	22.8	25.0	27.0
Private hospitals and sanitariums	140.2	152.4	166.3	182.3
Health insurance	21.6	22.4	25.9	29.8
Medical care and hospitalization	17.7	18.5	20.6	24.3
Income loss (disability)	2.3	2.5	2.6	2.7
Worker's compensation	1.7	1.5	2.7	2.7
Transportation	359.5	366.3	377.1	406.4
Household operation	334.1	347.5	363.0	386.4
Recreation	185.7	201.2	224.5	246.8
Personal business	169.9	192.5	232.2	234.4
Clothing, accessories and jewelry	193.3	207.2	220.5	234.2
Religious and welfare activities	57.1	62.9	68.2	76.1
Private education and research	43.3	46.6	51.1	58.0
Personal care	38.8	41.4	44.4	48.5
Foreign travel and other	13.1	6.5	7.0	3.2

*Drugs and sundries includes ophthalmic products and orthopedic appliances.

SOURCE: U.S. Department of Commerce, Bureau of Economic Analysis, Survey of Current Business, July 1989.

Table 4.6

Personal Consumption Expenditures for Medical Care by Type of Service (1950–1988) (Billions)

Year	Total medical care	Hospital services	Physicians' services	Drugs, sundries and appliances	Dentists' services	Net cost of health insurance	All other medical care
1950	8.8	2.1	2.6	2.2	1.0	0.3	0.8
1955	13.4	3.4	3.8	3.0	1.5	0.6	1.1
1960	20.6	5.6	5.8	4.7	2.0	0.8	1.8
1965	31.6	8.9	8.5	6.4	2.8	1.3	3.7
1966	34.3	10.1	9.1	6.7	3.0	1.4	4.0
1967	37.1	11.8	10.0	7.0	3.4	1.3	3.7
1968	42.5	14.1	10.9	7.8	3.7	2.0	4.1
1969	48.3	17.0	12.4	8.6	4.3	1.9	4.1
1970	55.0	19.7	14.0	10.0	4.9	2.1	4.3
1971	60.9	23.2	15.3	10.5	5.1	2.6	4.2
1972	67.6	25.9	16.6	11.5	5.6	3.5	4.5
1973	75.1	28.8	18.4	12.5	6.6	3.6	5.2
1974	84.3	33.7	20.3	13.6	7.3	3.6	5.8
1975	96.9	40.1	23.5	14.9	8.2	3.2	7.0
1976	109.9	46.6	25.8	16.5	9.3	3.6	8.4
1977	126.5	53.3	29.6	17.4	10.3	5.4	10.4
1978	141.0	61.0	32.3	19.2	11.3	4.7	12.4
1979	160.6	70.0	36.3	21.6	12.3	5.6	14.8
1980	185.7	82.0	42.0	23.5	13.7	6.9	17.6
1981	217.3	96.8	49.0	25.8	16.1	7.6	22.0
1982	242.7	110.3	54.4	27.6	17.4	8.8	24.1
1983	266.5	119.6	61.1	30.3	18.5	11.0	25.8
1984	296.1	130.6	67.1	33.0	19.8	15.2	30.4
1985	327.5	140.2	73.5	36.0	21.5	21.6	34.7
1986	357.6	152.4	80.6	39.2	22.8	22.4	40.2
1987	399.3	166.3	93.9	41.6	25.0	25.9	46.6
1988	443.0	182.3	105.0	44.7	27.0	29.3	54.3

NOTE: Some data are revised. The data exclude private expenditures in federal, state, city and other government hospitals and nursing homes. In some cases, the sum of the items does not equal the "total medical care" shown because of rounding.

SOURCE: U.S. Department of Commerce, Bureau of Economic Analysis, Survey of Current Business, various issues.

Table 4.7

Personal Consumption Expenditures for Medical Care as Percent of Disposable Personal Income and as Percent of Total Personal Consumption Expenditures (1950–1989)
(Billions)

Year	Personal consumption expenditures for medical care	Total personal consumption expenditures	Medical care as percent of total personal consumption expenditures	Disposable personal income	Medical care as percent of disposable income
1950	$ 8.8	$ 192.1	4.6	$ 207.5	4.3
1955	13.4	257.9	5.2	278.8	4.8
1960	20.6	330.7	6.2	358.9	5.7
1965	31.6	440.7	7.2	486.8	6.5
1970	55.0	640.0	8.6	715.6	7.7
1971	60.9	691.6	8.8	776.8	7.8
1972	67.6	757.6	9.0	839.6	8.1
1973	75.1	837.2	9.0	949.8	7.9
1974	84.3	916.5	9.2	1,038.3	8.1
1975	96.9	1,012.8	9.6	1,142.8	8.5
1976	109.9	1,129.3	9.7	1,252.6	8.8
1977	126.5	1,257.2	10.1	1,379.3	9.2
1978	141.0	1,403.5	10.0	1,151.2	12.2
1979	160.6	1,566.8	10.3	1,729.3	9.3
1980	185.7	1,732.6	10.7	1,917.9	9.7
1981	217.3	1,915.1	11.3	2,127.6	10.2
1982	242.7	2,050.7	11.8	2,261.4	10.7
1983	266.5	2,234.5	11.9	2,428.1	11.0
1984	296.1	2,430.5	12.2	2,668.6	11.1
1985	325.2	2,629.0	12.3	2,838.7	11.4
1986	357.6	2,797.4	12.8	3,013.3	11.8
1987	399.3	3,010.8	13.3	3,205.9	12.5
1988	443.0	3,235.1	13.7	3,477.8	12.7
1989	452.8	3,470.8	13.1	3,875.9	11.7

NOTE: Includes all expenses for health insurance except loss of income type of coverage.

SOURCES: U.S. Department of Commerce, Bureau of Economic Analysis, Survey of Current Business, various issues and Health Insurance Association of America.

Table 4.8

Annual Percent Change in Consumer Price Index (All Urban Consumers) (1969–1989)

Year	All items	All medical care items	Physicians' fees	Dentists' fees	Hospital room	Drugs and prescriptions: Prescription drugs	Drugs and prescriptions: Internal and respiratory over-the-counter drugs
1969	5.5	8.2	6.8	7.2	13.6	1.3	1.0
1970	5.7	7.0	6.6	5.7	12.9	1.7	2.7
1971	4.4	7.4	6.5	6.4	12.3	0.0	3.8
1972	3.2	3.5	3.6	4.1	6.4	−0.4	0.9
1973	6.2	4.5	3.4	3.2	5.0	−0.2	1.1
1974	11.0	10.4	8.5	7.6	10.5	2.3	4.5
1975	9.1	12.6	10.9	10.4	17.1	6.2	10.7
1976	5.8	10.1	9.3	6.2	13.8	5.3	6.8
1977	6.5	9.9	8.1	7.6	11.5	6.1	6.9
1978	7.6	8.5	7.5	7.1	11.1	7.7	7.1
1979	11.3	9.8	8.7	8.3	11.3	7.8	7.4
1980	13.5	11.3	11.1	11.9	13.1	9.2	10.1
1981	10.3	10.7	10.3	9.6	14.9	11.4	12.4
1982	6.2	11.8	8.5	7.6	15.7	11.6	10.8
1983	3.2	8.7	7.1	6.8	11.3	11.0	7.5
1984	4.3	6.0	7.2	8.1	8.3	9.6	6.2
1985	3.6	6.1	6.1	6.2	5.9	9.5	5.4
1986	1.9	7.7	6.4	5.6	6.0	8.6	4.9
1987	3.6	6.6	6.6	6.8	7.2	8.0	5.3
1988	4.1	6.4	6.8	6.8	9.3	8.0	5.6
1989	4.8	7.7	6.5	6.3	10.3	8.7	6.1

SOURCE U.S. Department of Labor, Bureau of Labor Statistics, CPI Detailed report, various issues.

Table 4.9

Community Hospital Statistics by State (1988)

State	Number of hospitals	Hospital beds	Occupancy rate	Admissions	Average cost to hospital per day*	Average length of hospital stay	Average cost to hospital per stay*
Total United States	5,533	946,697	65.5	31,452,835	$586.33	7.2	$4,206.73
Alabama	120	18,768	59.5	594,658	505.77	6.9	3,470.69
Alaska	16	1,218	49.3	37,555	961.32	5.8	5,616.07
Arizona	62	10,108	63.6	393,780	759.71	6.0	4,527.36
Arkansas	88	10,701	57.1	342,150	462.91	6.5	2,994.43
California	464	81,727	64.2	3,032,240	804.16	6.3	5,060.60
Colorado	79	10,657	61.3	336,202	626.83	7.1	4,432.37
Connecticut	36	9,662	76.5	363,824	685.42	7.4	5,064.93
Delaware	8	2,005	77.0	80,351	628.32	7.0	4,390.74
District of Columbia	12	4,716	76.3	172,933	811.38	7.6	6,149.92
Florida	235	51,175	61.6	1,644,681	646.19	7.0	4,506.01
Georgia	164	25,434	65.9	900,070	515.96	6.8	3,487.75
Hawaii	18	2.789	82.8	95,243	517.16	8.9	4,651.11
Idaho	43	3,235	56.6	97,845	456.87	6.8	3,150.96
Illinois	220	49,713	62.5	1,540,685	632.96	7.4	4,645.53
Indiana	115	22,831	58.6	738,878	571.87	6.6	3,750.37
Iowa	127	14,616	60.7	395,479	431.67	8.2	3,546.70
Kansas	137	11,636	56.6	309,087	448.33	7.8	3,497.85
Kentucky	108	16,004	60.2	546,201	485.04	6.5	3,107.62
Louisiana	141	19,142	55.1	613,475	604.78	6.3	3,784.47
Maine	40	4,576	71.1	147,690	475.20	8.1	3,808.36
Maryland	53	13,422	77.2	547,572	579.47	6.9	3,996.61
Massachusetts	108	23,224	73.2	792,723	671.05	7.8	5,225.09
Michigan	177	34,590	65.8	1,121,243	643.92	7.4	4,711.68
Minnesota	158	20,599	63.6	534,870	458.04	9.0	4,103.50
Mississippi	108	13,298	57.7	406,353	375.23	6.9	2,592.69
Missouri	135	24.665	61.9	747,845	577.57	7.5	4,287.65
Montana	58	4,476	62.7	108,558	353.55	9.4	3,311.94
Nebraska	95	9,229	55.7	190,071	414.06	9.9	4,092.77
Nevada	22	3,434	54.9	110,921	762.92	6.2	4,840.09
New Hampshire	28	3,518	65.3	123,394	546.25	6.8	3,685.18
New Jersey	92	28,690	77.4	1,097,712	509.50	7.4	3,773.66
New Mexico	38	4,089	59.6	156,093	669.71	5.6	3,792.67
New York	246	74,682	85.2	2,414,061	529.68	9.6	5,069.73
North Carolina	128	21,708	71.1	772,375	487.00	7.3	3,537.68
North Dakota	51	4,631	63.8	103,200	376.75	10.5	3,868.81
Ohio	194	45,911	64.6	1,577,530	612.13	6.9	4,172.70
Oklahoma	115	12,865	57.3	402,901	546.78	6.7	3,631.63
Oregon	71	7,970	56.6	302,228	703.47	5.5	3,833.12
Pennsylvania	239	52,400	70.9	1,796,470	583.14	7.6	4,370.03
Rhode Island	13	3,256	83.0	122,933	545.51	8.0	4,396.07
South Carolina	72	11,348	67.2	394,919	473.92	7.0	3,346.69
South Dakota	54	3,975	59.3	95,581	359.76	9.0	3,214.05
Tennessee	136	23,615	64.6	806,629	517.45	6.9	3,545.48
Texas	444	61,110	55.3	1,987,440	628.21	6.2	3,883.53
Utah	41	4,513	56.5	173,332	737.33	5.4	3,879.17
Vermont	16	1,772	66.0	57,953	491.27	7.4	3,587.71
Virginia	98	20,172	66.9	705,694	528.72	7.0	3,689.66
Washington	96	12,436	59.7	479,436	707.63	5.7	3,984.12
West Virginia	58	8,704	60.9	286,019	493.94	6.8	3,318.70
Wisconsin	129	19,461	62.5	599,613	483.51	7.4	3,583.33
Wyoming	27	2,221	52.1	54,139	415.73	7.6	3,107.29

*Reported by hospital as expense.

SOURCE: American Hospital Association. Hospital Statistics, 1989.

Table 4.10

Percent Change in Selected Components of Consumer Prices, Urban Consumers (1980–1989)

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989
All items	13.5	10.3	6.2	3.2	4.3	3.6	1.9	3.6	4.1	4.8
Food/beverages	8.5	7.8	4.1	2.3	3.7	2.3	3.3	4.0	4.1	5.7
Housing	15.7	11.5	7.2	2.7	4.1	4.0	3.0	3.0	3.8	3.8
Apparel/upkeep	7.1	4.8	2.6	2.5	1.9	2.8	0.9	4.4	4.3	2.8
Transportation	11.0	10.7	11.6	8.8	6.2	6.3	7.5	6.6	6.5	5.0
Medical care	11.0	10.7	11.6	8.8	6.2	6.3	7.5	6.6	6.5	7.7
Entertainment	9.0	7.8	6.5	4.3	3.7	3.9	3.4	3.3	4.3	6.4
Other goods and services	9.1	9.8	10.3	11.0	6.7	6.1	6.0	5.8	6.3	7.8

SOURCE: U.S. Department of Labor, Monthly Labor Review

Table 4.11

Hospital Semiprivate Room Charges by State and Territory (1987–1990)

States and Territories	January 1987	January 1988	Percent change 1987–1988	January 1989	January 1990	Percent change 1989–1990
Average United States	$239	$255	6.7	$264	$297	12.5
Alabama	176	187	6.2	187	210	12.3
Alaska	318	331	4.0	378	407	7.7
Arizona	233	251	7.9	256	300	17.2
Arkansas	155	159	2.7	161	170	5.6
California	328	361	9.9	391	453	15.9
Colorado	242	261	7.9	375	321	17.5
Connecticut	333	344	3.3	396	456	15.2
Delaware	305	325	6.6	350	385	10.0
District of Columbia	423	449	6.2	325	325	0.0
Florida	202	218	7.9	239	271	13.4
Georgia	152	162	6.6	180	198	10.0
Hawaii	242	257	6.4	317	348	9.8
Idaho	230	250	8.6	233	259	11.2
Illinois	265	276	3.9	275	300	9.1
Indiana	206	224	8.9	225	258	14.7
Iowa	193	202	4.8	210	221	5.2
Kansas	201	216	7.7	239	256	7.1
Kentucky	199	215	8.4	217	242	11.5
Louisiana	200	209	4.4	181	203	12.2
Maine	232	257	10.9	279	335	20.1
Maryland	213	232	8.6	233	266	14.2
Massachusetts	286	312	8.9	327	351	7.3
Michigan	180	294	5.0	313	337	7.7
Minnesota	223	244	9.1	244	282	15.6
Mississippi	125	141	12.8	142	167	17.6
Missouri	213	226	5.7	246	268	8.9
Montana	214	219	2.1	7	318	12.0
Nebraska	173	182	5.4	185	209	13.0
Nevada	223	224	0.2	239	251	5.0
New Hampshire	221	238	7.9	272	304	11.8
New Jersey	212	229	7.7	226	273	20.8
New Mexico	232	234	0.8	240	254	5.8
New York	254	266	4.5	301	339	12.6
North Carolina	157	174	11.3	185	220	18.9
North Dakota	184	195	6.0	213	230	7.9
Ohio	261	276	5.5	281	38	9.6
Oklahoma	178	188	5.2	205	220	7.3
Oregon	263	287	8.8	301	338	12.3
Pennsylvania	284	301	6.0	318	375	17.9
Puerto Rico	131	140	6.5	154	158	2.6
Rhode Island	244	275	12.6	296	342	15.5
South Carolina	145	160	9.8	199	212	6.5
South Dakota	175	182	4.1	187	208	11.8
Tennessee	162	173	6.7	172	182	5.8
Texas	183	199	8.4	202	223	10.4
Utah	234	242	3.5	328	353	7.6
Vermont	257	284	10.7	303	378	24.8
Virginia	181	195	7.7	194	220	13.4
Washington	268	281	4.7	298	334	12.1
West Virginia	181	196	8.5	213	223	4.7
Wisconsin	172	186	8.3	214	222	3.7
Wyoming	177	189	6.6	219	234	6.9

SOURCE: Health Insurance Association of America, Hospital Semi-Private Room Charges Survey, 1989.

Table 4.12

Median Physicians' Fees for Surgical Procedures by Specialty (1989)

Specialty	Fees
General surgery	
Appendectomy	$ 801
Cholecystectomy	1,029
Inguinal hernia (unilateral)	800
Modified radical mastectomy	1,489
Obstetrics/Gynecology	
Complete obstetrical care (usual or routine)	1,569
Total hysterectomy	1,770
Dilation and Curettage (diagnostic)	450
Dilation and Curettage (therapeutic for abortion)	451
Thoracic surgery	
Coronary artery bypass with three autogenous grafts	4,834
Lobectomy	2,250
Implant pacemaker	1,500
Thoracentesis	151
Abdominal aortic aneurysm repair	3,001
Neurosurgery	
Cranioplasty	$2,500
Craniotomy	3,501
Lumbar laminectomy	2,501
Cervical fusion (anterior)	2,970
Plastic surgery	
Complete rhinoplasty	2,500
Facial rhytidectomy	3,500
Breast augmentation (bilateral)	2,397
Dermabrasion of facial scar	500
Excision of lipoma	301
Blepharoplasty, upper eyelids	1,238
Breast reduction (bilateral)	3,501
Orthopedic surgery	
Wrist ganglionectomy	478
Diagnostic knee arthroscopy	708
Excision of knee cartilage	1,501
Closed reduction of Colles' fracture	426
Total hip arthroplasty	3,500
Total knee arthroplasty	3,318

SOURCE: Medical Economics, October 2, 1989. Copyright © 1989 and published by Medical Economics Company, Inc., Oradell, N.J. 07649. Reprinted by permission.

Table 4.13

Median Physicians' Fees for Office Visits by Region by Specialty (1989)

	First office visits				Office revisits			
Specialty	**West**	**Midwest**	**South**	**East**	**West**	**Midwest**	**South**	**East**
Family practice	$ 40	$ 30	$ 31	$35	$31	$25	$26	$29
General practice	43	30	31	36	33	25	25	30
Internal medicine	56	41	56	55	36	29	31	36
Obstetrics/Gynecology	70	49	55	73	40	31	35	41
Pediatricians	46	35	36	41	35	27	28	33
General surgeons	51	35	41	46	31	26	28	31
Neurosurgeons	153	100	101	*	41	31	36	*
Orthopedic surgeons	58	45	50	70	36	29	30	41
Plastic surgeons	50	*	41	*	*	*	26	*
Thoracic surgeons	*	*	75	*	*	*	31	*
All surgical specialists	62	45	50	61	35	29	30	40
All nonsurgical specialists (except family practice and general practice)	60	45	41	55	36	29	31	36

*Data incomplete.

SOURCE: Medical Economics, October 2, 1989. Copyright © 1989 and published by Medical Economics Company, Inc., Oradell, N.J. 07649. Reprinted by permission.

Table 4.14

Cost of Maternity Care, Physicians' Fees and Hospital Charges by Census Region (Weighted Averages)

United States

	Normal delivery			Cesarean delivery		
	Total	Metropolitan	Nonmetropolitan	Total	Metropolitan	Nonmetropolitan
Total	$4,334	$4,564	$4,128	$7,186	$7,633	$6,736
Hospital charges	2,842	2,925	2,749	5,133	5,288	4,916
Physicians' fees	1,492	1,639	1,379	2,053	2,345	1,820

Regions

	Normal delivery	Cesarean delivery
Northeast		
Total	$4,456	$7,879
Hospital charges	2,964	5,826
Physicians' fees	1,492	2,053
Midwest		
Total	4,149	6,741
Hospital charges	2,657	4,688
Physicians' fees	1,492	2,053
South		
Total	4,204	7,087
Hospital charges	2,712	5,034
Physicians' fees	1,492	2,053
West		
Total	4,237	7,586
Hospital charges	2,745	5,533
Physicians' fees	1,492	2,053

NOTE: Physicians' fees include prenatal charges and delivery fees.

SOURCES: Health Insurance Association of America, The Cost of Maternity Care and Childbirth in the United States, 1989 and 1989 HIAA Surgical Prevailing Healthcare Charges System.

Table 4.15

Mental Disorders by Age, Sex, Race and Region (1988)
(Thousands)

	Total mental disorders	Psychoses	Alcohol dependence syndrome
Age			
Total	5,141	1,562	842
Under 15 years	1,100	314	*
15–44 years	138	17	*
45–64 years	2,559	627	470
65 years and more	1,344	604	103
Sex			
Male	2,619	715	621
Female	2,521	847	211
Race			
White	3,764	1,136	591
All other	878	258	185
Not stated	499	168	86
Region			
Northeast	1,244	404	245
Midwest	1,480	429	265
South	1,467	431	189
West	949	298	143

*Age not verified.

SOURCE: National Center for Health Statistics, April 1989

Table 4.16

Visits and Charges for Psychotherapy by State (1988–1989)

State	Psychotherapy visits per 1,000 people 1988	Psychotherapy visits per 1,000 people 1989	Average charge per visit 1988	Average charge per visit 1989
Total United States	343	350	$71	$72
Alabama	100	87	67	67
Alaska	324	322	90	89
Arizona	457	592	81	85
Arkansas	62	100	70	68
California	414	520	80	70
Colorado	907	875	73	76
Connecticut	974	900	81	87
Delaware	NA	NA	NA	NA
District of Columbia	490	1,374	74	81
Florida	508	311	88	80
Georgia	211	172	81	82
Hawaii	NA	NA	NA	NA
Idaho	182	200	64	72
Illinois	484	413	74	76
Indiana	62	134	63	80
Iowa	209	192	50	52
Kansas	244	423	73	71
Kentucky	259	377	58	72
Louisiana	65	96	68	67
Maine	65	NA	NA	NA
Maryland	298	259	69	71
Massachusetts	520	611	72	72
Michigan	253	235	73	70
Minnesota	352	302	70	73
Mississippi	NA	NA	NA	NA
Missouri	291	319	63	70
Montana	320	383	58	60
Nebraska	234	269	56	59
Nevada	NA	NA	NA	NA
New Hampshire	648	743	85	76
New Jersey	637	281	76	80
New Mexico	288	603	71	83
New York	1,221	1,267	82	89
North Carolina	202	131	60	61
North Dakota	NA	NA	NA	NA
Ohio	205	178	66	67
Oklahoma	71	65	65	69
Oregon	538	644	67	74
Pennsylvania	288	168	67	62
Rhode Island	NA	NA	NA	NA
South Carolina	NA	NA	NA	NA
South Dakota	81	129	63	63
Tennessee	133	145	69	72
Texas	318	349	78	82
Utah	568	859	61	74
Vermont	NA	NA	NA	NA
Virginia	503	720	77	66
Washington	367	502	65	68
West Virginia	NA	205	NA	62
Wisconsin	342	285	64	69
Wyoming	199	NA	62	NA

SOURCE: Mutual of Omaha Insurance Company, Current Trends in Health Care Costs and Utilization.

Table 4.17

Cost of High-Technology Medical Procedures (1989)

Procedure	Cost of the procedure to the patient
Cardiovascular	
Thrombolytic agents (blood clot dissolver)	$ 8,000
PTCA (coronary angioplasty)	4,000
Pacemaker (advanced)	7,000
Implantable defibrillator	12,000
Orthopedics	
Bone growth devices for spinal surgery	6,000
Bone growth stimulator	2,000
Ear, nose, throat	
Cochlear implants	4,000
Urological	
Penile prosthesis	4,000
Drug delivery	
Implantable drug infusion pumps	1,800
Diagnostic imaging	
MRI (Magnetic resonance image)	850
High-speed Cine-CT	700
Other technologies	
Peripheral vascular angioplasty	4,000
Lithotripsy	10,000
Valvuloplasty (opening blocked aorta valve)	6,000

*Estimated costs of procedures include hospital costs only. Physicians' fees are not included.

SOURCE: The Wilkerson Group Project Hope, 1989.

Table 4.18

Surgical Procedure Utilization and Average Charge Per Procedure (Mutual of Omaha Insurance Company Claimants Only) (1988–1989)

	Inpatient Surgeries				Outpatient Surgeries			
	Number of surgeries per 1,000 people		Average charge per surgery		Number of surgeries per 1,000 people		Average charge per surgery	
State	1988	1989	1988	1989	1988	1989	1988	1989
Total United States	73	74	$ 915	$ 980	49	56	$501	$539
Alabama	97	74	836	967	71	57	471	555
Alaska	NA	51	NA	1,398	NA	60	NA	681
Arizona	66	96	1,156	1,153	60	80	622	660
Arkansas	59	66	757	897	42	51	421	510
California	54	74	1,248	1,214	33	55	759	749
Colorado	67	67	962	1,013	55	65	486	523
Connecticut	NA	NA	NA	NA	NA	NA	NA	NA
Delaware	NA	NA	NA	NA	NA	NA	NA	NA
District of Columbia	NA	NA	NA	NA	NA	NA	NA	NA
Florida	159	67	1,290	1,241	92	50	613	654
Georgia	68	63	1,034	1,044	34	33	633	577
Hawaii	NA	NA	NA	NA	NA	NA	NA	NA
Idaho	108	87	748	889	NA	NA	NA	NA
Illinois	81	85	1,074	1,099	57	65	530	557
Indiana	84	97	926	1,001	65	77	460	550
Iowa	77	61	738	849	57	52	395	409
Kansas	89	78	852	973	63	94	370	439
Kentucky	98	125	955	1,017	95	147	442	424
Louisiana	55	65	830	758	27	37	428	465
Maine	NA	NA	NA	NA	NA	NA	NA	NA
Maryland	77	56	1,062	1,400	48	57	664	539
Massachusetts	96	69	1,096	1,320	80	73	479	503
Michigan	65	77	783	915	60	110	445	472
Minnesota	77	86	782	888	51	55	456	445
Mississippi	55	56	760	813	33	30	477	465
Missouri	82	83	914	1,038	60	62	482	556
Montana	66	68	860	946	39	42	433	504
Nebraska	77	82	661	711	55	65	424	444
Nevada	NA	NA	NA	NA	NA	NA	NA	NA
New Hampshire	NA	NA	NA	NA	NA	NA	NA	NA
New Jersey	95	69	1,198	1,309	49	NA	604	NA
New Mexico	NA	84	NA	1,000	NA	79	NA	625
New York	62	79	1,779	1,661	28	46	890	693
North Carolina	71	89	897	883	54	52	557	515
North Dakota	NA	NA	NA	NA	NA	NA	NA	NA
Ohio	62	71	862	889	52	61	399	443
Oklahoma	66	84	937	917	65	89	434	321
Oregon	89	81	1,003	1,083	65	55	578	600
Pennsylvania	54	44	1,104	1,338	48	49	576	533
Rhode Island	NA	NA	NA	NA	NA	NA	NA	NA
South Carolina	NA	NA	NA	NA	NA	NA	NA	NA
South Dakota	79	85	776	808	41	55	359	517

Continued

Tennessee	64	65	786	852	35	46	423	499
Texas	71	69	957	1,062	42	48	565	619
Utah	96	96	868	860	114	125	495	473
Vermont	NA	NA	NA	NA	NA	NA	NA	NA
Virginia	86	66	975	1,120	NA	74	NA	642
Washington	60	60	1,148	1,237	33	39	535	582
West Virginia	NA	126	NA	800	NA	NA	NA	NA
Wisconsin	105	97	713	817	66	59	432	415
Wyoming	53	NA	870	NA	NA	NA	NA	NA

SOURCE: Mutual of Omaha Insurance Company, Current Trends in Health Care Costs and Utilization.

Table 4.19

Cost of Accidents by Class (Billions)

	Total	Motor vehicle	Work	Home	Public nonmotor vehicle
Total costs	$143.4	$70.2	$47.1	$17.4	$10.9
Wage loss	37.1	20.3	7.9	5.8	4.7
Medical expense	23.6	5.0	8.1	6.7	4.4
Insurance administration	28.7	21.3	6.0	0.8	0.6
Fire loss	8.4	NA	3.1	4.1	1.2
Motor vehicle property damage	23.6	23.6	NA	NA	NA
Indirect work loss	22.0	NA	22.0	NA	NA

NOTE: Duplications between work and motor vehicle are eliminated in totals. Home and public insurance administration may include costs of administering medical treatment claims for some motor vehicle injuries through health plans.

SOURCE: National Safety Council, 1989.

Chapter 5

HEALTH SERVICES, RESOURCES AND UTILIZATION

Community hospitals (defined as nonfederal, short-term, general and special hospitals) provide acute care to the public. They account for 82 percent of all hospitals and 92 percent of all the hospital admissions in the United States.

According to the 1989–90 edition of *Hospital Statistics*, published by the American Hospital Association, community hospital admissions dropped slightly to 31.5 million in 1988 from 31.6 million in 1987. The number of beds in community hospitals dropped from 4.0 to 3.9 and admissions rates dropped from 132.4 to 128.9 per 1,000 persons in the United States in 1988. (Table 5.1) Hospitals reported 269 million outpatient visits in 1988, almost a 10 percent increase over the previous year, continuing a trend toward the use of new facilities for the treatment of both medical and psychiatric patients on an outpatient basis. The increase in outpatient visits reported in 1988 is the highest rate of growth in outpatient use in more than a decade.

The increasing use of ambulatory care as an alternative to hospitalization is evident in the proliferation of ambulatory care centers across the United States and the number of patient visits to these centers. In the United States, 77.5 percent of community hospitals now have organized outpatient service departments providing outpatient surgery, examination, diagnosis and treatment of a variety of nonemergency medical conditions on an ambulatory basis.

Special geriatric services are offered at 990 community hospitals across the country. Hospice service, a concept of palliative care for the dying, is available at 767 hospitals and at an increasing number of freestanding facilities across the United States. To be eligible for reimbursement by Medicare, hospices must be certified by the U.S. Department of Health and Human Services.

◆ Utilization by Diagnosis

With the exception of obstetrical procedures for women, operations on the digestive system were the most common type of procedure performed on both sexes.

According to the National Center for Health Statistics the most frequent diagnoses for patients under 15 years of age were infectious and parasitic diseases, pneumonia and chronic disease of the tonsils and adenoids. Mental disorders, diseases of the genito-urinary system, fractures and heart disease were the most frequent diagnoses of patients 15 to 44 years of age, excluding females with obstetrical deliveries. Patients 45 to 64 years of age were hospitalized most frequently for heart disease and the most common diagnoses for those 65 years of age and over were heart disease and malignant neoplasms. (Table 5.3)

Women are operated on more frequently than men. In 1988, there were 23.5 million surgical procedures performed on women and 15.7 million on men. The majority of the surgical procedures were performed on people in the 15 to 44 age group. (Table 5.4)

◆ Physician Visits

Physicians in the South see more patients than physicians in any other part of the United States. A 1989 American Medical Association publication, *Socioeconomic Characteristics of Medical Practice*, found that each family physician in the South saw 158.4 patients per week, 16.4 more than the national average. In 1988, pediatricians saw more patients per week than any other specialty. (Table 5.5)

Since 1980, community hospitals have increased their patient services and the number of special beds. (Table 5.6) New facilities reflect a greater emphasis on nonacute care and outpatient services.

Americans remain in the hospital on the average for shorter stays while undergoing treatment for disease or recuperating from surgical procedures than any other country in the world with the exception of diagnosis of respiratory distress syndrome. (Table 5.7)

◆ Hospital Facilities and Numbers of Physicians

HCFA estimates the number of practicing physicans will increase from 588,000 in 1990 to 697,000 in the year 2000, an increase of almost 19 percent. (Table 5.8)

The number of community hospitals, many in rural areas, has been declining since 1977. Since 1980, 440 community hospitals have ceased to provide inpatient acute care services. In 1988 there were 5,533 community hospitals in operation.

The decrease in the number of hospitals was accompanied by a decline in the number of hospital beds. The number decreased from 958,000 in 1987 to 947,000 in 1988, a 1.2 percent decrease in one year. (Table 5.9)

Although fewer beds are available, the scope of services has increased with advances in medical technology. Hospitals are able to offer more types of procedures and treatments to patients on an outpatient basis. Occupancy in community hospitals continues to decrease due to expanded outpatient and ambulatory patient services.

◆ Organ Transplants

Kidney transplants composed the majority (9,123) of the 12,798 organ transplants performed at 221 transplant centers in the United States in 1988. Despite development of new technology and more effective immunosuppressant drugs that promise safe and effective procedures and better recovery, 18,575 patients awaited organ transplants at the end of 1989 due to the scarcity of transplantable organs. (Table 5.10)

Table 5.1

Community Hospital Statistics (1950–1988)

Year	Beds per 1,000 population	Occupancy rates (percent)	Average number of persons hospitalized per day per 1,000 population	Admissions per 1,000 population	Average length of stay (days)
1950	3.4	NA	2.5	111.4	8.1
1955	3.5	NA	2.5	117.3	7.8
1960	3.6	NA	2.7	129.2	7.6
1965	3.9	NA	3.0	138.8	7.8
1970	4.2	NA	3.3	145.6	8.2
1975	4.5	77.4	3.3	158.1	7.7
1980	4.4	75.6	3.3	162.1	7.6
1981	4.5	76.0	3.4	161.9	7.6
1982	4.5	75.3	3.4	160.2	7.6
1983	4.4	73.5	3.3	157.6	7.6
1984	4.4	64.8	3.0	151.8	7.3
1985	4.3	64.3	2.8	143.1	7.1
1986	4.1	64.9	2.7	137.0	7.1
1987	4.0	64.9	2.6	132.4	7.2
1988	3.9	65.7	2.5	128.9	7.2

SOURCE: American Hospital Association, Hospital Statistics, (various annual editions).

Table 5.2

Number and Rate of Patients Discharged from Short-Stay Hospitals, Days of Care, Average Lengths of Stay by Sex and Age (1988)

	Discharged patients		Days of care		
Sex and age	**Numbers in thousands**	**Rate per 1,000 population**	**Numbers in thousands**	**Rate per 1,000 population**	**Average length of stay in days**
Total all ages	**31,146**	**127.6**	**203,678**	**834.3**	**6.5**
Under 15 years	2,610	49.2	13,028	245.3	5.0
Under 1 year	774	200.6	5,150	1334.5	6.7
1–4 years	778	53.3	2,800	191.8	3.6
5–14 years	1,058	30.5	5,079	146.5	4.8
15–44 years	11,935	104.0	56,558	493.1	4.7
15–19 years	1,485	82.2	7,400	409.6	5.0
20–24 years	2,246	120.6	8,638	463.8	3.8
25–34 years	5,019	116.6	22,534	523.7	4.5
35–44 years	3,184	91.0	17,986	514.2	5.6
45–64 years	6,456	140.5	43,901	955.3	6.8
45–54 years	2,797	115.9	17,249	715.0	6.2
55–64 years	3,659	167.6	26,651	1221.0	7.3
65 years and over	10,146	334.1	90,191	2970.0	8.9
65–74 years	4,718	263.6	39,759	2221.5	8.4
75–84 years	3,891	408.6	35,691	3748.6	9.2
85 years and more	1,538	521.8	14,741	5000.4	9.6
Under 17 years	3,042	47.6	15,770	247.0	5.2
17–69 years	20,329	124.2	117,156	715.5	5.8
70 years and more	7,775	381.6	70,752	3472.5	9.1
Male all ages	**12,642**	**106.9**	**89,435**	**756.5**	**7.1**
Under 15 years	1,486	54.6	7,493	275.5	5.0
Under 1 year	442	223.7	2,975	1505.3	6.7
1–4 years	455	60.8	1,628	218.0	3.6
5–14 years	589	33.2	2,890	162.8	4.9
15–44 years	3,485	61.5	21,996	388.2	6.3
15–19 years	454	49.6	3,200	349.5	7.1
20–24 years	485	53.2	2,746	301.5	5.7
25–34 years	1,208	56.7	7,700	361.7	6.4
35–44 years	1,339	76.0	8,351	473.7	6.2
45–64 years	3,221	146.4	21,855	993.2	6.8
45–54 years	1,341	114.4	8,356	713.4	6.2
55–64 years	1,880	182.7	13,499	1311.8	7.2
65 years and over	4,450	360.3	38,091	3083.5	8.6
65–74 years	2,311	290.9	18,927	2382.6	8.2
75–84 years	1,626	453.5	14,412	4021.1	8.9
85 years and more	514	622.9	4,752	5760.1	9.2
Under 17 years	1,658	50.7	8,846	270.6	5.3
17–69 years	7,734	97.1	52,096	653.8	6.7
70 years and more	3,250	416.2	28,492	3648.6	8.8

Continued

Female all ages	**18,504**	**147.0**	**114,242**	**907.4**	**6.2**
Under 15 years	1,125	43.4	5,536	213.6	4.9
Under 1 year	332	176.2	2,175	1155.2	6.6
1–4 years	324	45.4	1,172	164.4	3.6
5–14 years	469	27.8	2,189	129.5	4.7
15–44 years	8,448	145.6	34,562	595.6	4.1
15–19 years	1,032	115.8	4,200	471.4	4.1
20–24 years	1,761	185.0	5,893	619.1	3.3
25–34 years	3,811	175.2	14,834	682.1	3.9
35–44 years	1,845	103.3	9,635	539.7	5.2
45–64 years	3,235	135.1	22,046	920.5	6.8
45–54 years	1,457	117.4	8,893	716.6	6.1
55–64 years	1,779	154.2	13,152	1139.9	7.4
65 years and more	5,696	316.2	52,100	2892.3	9.1
65–74 years	2,407	241.8	20,832	2093.0	8.7
75–84 years	2,265	381.5	21,279	3584.1	9.4
85 years and more	1,024	482.2	9,989	4703.0	9.8
Under 17 years	1,384	44.4	6,923	222.3	5.0
17–69 years	12,595	149.8	65,059	774.0	5.2
70 years and more	4,525	360.1	42,260	3363.0	9.3

SOURCE National Center for Health Statistics, Advancedata.

Table 5.3

Patients Discharged from Short-Stay Hospitals by Category of First-Listed Diagnosis, Sex and Age (1988) (Thousands)

First-listed diagnostic category	Total	Sex: Male	Sex: Female	Age: Under 15 years	Age: 15–44 years	Age: 45–64 years	Age: 65 years or more
All conditions	31,146	12,642	18,504	2,610	11,934	6,456	10,146
Heart disease	3,641	1,955	1,686	14	243	1,162	2,223
Malignant neoplasms and carcinoma-in-situ	1,570	772	898	37	187	566	880
Benign neoplasms and neoplasms of uncertain behavior	428	78	350	16	191	142	79
Fractures, all sites	1,014	506	508	107	356	154	398
Diseases of the genitourinary system	2,204	828	1,376	71	922	512	700
Pneumonia, all forms	924	472	452	184	111	139	490
Chronic disease of tonsils and adenoids	197	87	110	125	70	—	—
Cerebrovascular disease	784	336	448	—	32	171	578
Diabetes mellitus	454	209	245	28	125	134	166
Inguinal hernia	257	232	25	30	65	78	84
Cholelithiasis	484	132	352	—	183	146	154
Appendicitis	242	141	101	52	145	24	20
Mental disorders	1,559	765	793	58	962	288	251
Infectious and parasitic diseases	693	333	359	191	211	104	187
Hyperplasia of the prostate	247	247	—	—	—	56	191
Females with obstetrical deliveries	3,781	—	3,781	10	3,768	—	—

SOURCE: National Center for Health Statistics, Advancedata, 1989.

Table 5.4

Procedures Provided to Patients Discharged from Short-Stay Hospitals by Category, Sex and Age (1988) (Thousands)

		Sex		Age			
Procedure	**Total**	**Male**	**Female**	**Under 15 years**	**15–44 years**	**45–64 years**	**65 years or more**
All procedures	39,192	15,735	23,457	2,050	15,520	8,939	12,682
Operations on the nervous system	896	467	429	216	279	200	201
Operations on the endocrine system	111	31	79	—	43	39	26
Operations on the eye	547	243	304	33	80	126	308
Operations on the ear	198	109	88	107	46	25	19
Operations on the nose, mouth and pharynx	820	436	385	220	372	135	94
Operations on the respiratory system	991	561	430	69	190	291	441
Operations on the cardiovascular system	3,626	2,220	1,406	169	422	1,358	1,676
Operations on the hemic and lymphatic system	392	192	200	24	91	106	172
Operations on the digestive system	5,257	2,277	2,981	233	1,244	1,335	2,145
Operations on the urinary system	1,706	1,018	688	48	398	426	833
Operations on the male genital organs	633	633	—	50	54	128	400
Operations on the female genital organs	2,501	—	2,501	10	1,773	516	202
Obstetrical procedures	6,042	—	6,042	16	6,024	—	—
Operations on the musculoskeletal system	3,143	1,648	1,496	203	1,325	747	868
Operations on the integumentary system	1,475	639	836	105	537	393	440
Miscellaneous diagnostic and therapeutic procedures	10,854	5,262	5,593	544	2,342	3,112	4,856

NOTE: Details may not add to total due to rounding.

SOURCE: National Center for Health Statistics. Advancedata, 1989.

Table 5.5

Average Number of Patient Visits Per Week by Physician Specialty and Census Division (1982–1988)

	1982	1983	1984	1985	1986	1987	1988
Specialty							
General/Family practice	161.3	148.4	139.0	138.1	139.2	138.3	145.6
Internal medicine	117.0	113.4	107.7	105.2	111.1	114.5	113.0
Surgery	113.1	111.9	110.1	108.2	105.8	107.8	105.0
Pediatrics	134.4	137.4	128.7	130.8	131.9	127.4	135.1
Obstetrics/Gynecology	126.6	118.2	115.7	112.0	114.8	112.7	118.9
Census Division							
New England	129.1	113.3	108.7	98.2	109.5	112.0	105.0
Middle Atlantic	120.2	121.5	114.4	110.9	110.3	109.5	113.9
East North Central	135.1	127.5	123.1	122.6	121.3	125.7	124.6
West North Central	137.7	141.3	128.6	117.6	122.0	128.9	136.0
Mountain South Atlantic	131.2	123.4	119.9	122.3	118.9	122.3	123.6
East South Central	150.4	149.8	153.8	127.5	148.9	151.1	158.4
West South Central	139.9	138.6	132.6	127.5	126.3	125.7	119.8
Mountain	128.3	121.1	114.2	109.9	111.2	115.0	118.6
Pacific	112.3	100.9	94.7	102.4	107.4	104.2	111.6

NOTE: Census Divisions are categorized as follows:
Northeast: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
Middle Atlantic: New Jersey, New York, Pennsylvania
East North Central: Illinois, Indiana, Michigan, Ohio, Wisconsin
West North Central: Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota
South Atlantic: Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia
East South Central: Alabama, Kentucky, Mississippi, Tennessee
West South Central: Arkansas, Louisiana, Oklahoma, Texas
Mountain: Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming
Pacific: Alaska, California, Hawaii, Oregon, Washington.

SOURCE: American Medical Association. Socioeconomic Characteristics of Medical Practice, 1989.

Table 5.6

Percent of Community Hospitals with Selected Special Facilities, Services and Special Beds (1980–1988)

Facility	1980	1982	1984	1986	1987	1988
Emergency department	82	94	86	95	95	95
Rehabilitation (outpatient)	25	33	36	38	41	41
Family planning	20	11	12	29	32	32
Open-heart facility	22	11	11	13	14	14
X-ray therapy	21	20	17	18	18	18
Megavolt therapy	16	17	15	18	18	18
Radioactive implants	26	23	21	24	24	24
Organ transplantation	NA	4	NA	5	6	6
Blood bank	79	72	67	73	71	71
Respiratory therapy	94	91	85	93	92	92
Speech pathology	43	37	44	50	47	47
Hemodialysis (inpatient)	24	23	24	28	27	27
Genetic counseling	7	7	8	8	8	8
Physical therapy	88	88	87	91	88	88
Occupational therapy	33	36	45	46	45	45
Psychiatric partial hospital	12	10	14	12	17	17
Psychiatric (outpatient)	17	14	21	17	17	17
Alcohol-chemical dependency	15	12	18	18	19	19
Home care department	12	13	21	35	35	35
Hospice	6	9	10	15	15	15
CT scanners	23	31	42	60	60	60
Nuclear magnetic resonance	NA	NA	NA	10	9	9

SOURCE: American Hospital Association, Hospital Statistics.

Table 5.7

Length of Stay for Selected Disease Categories in Selected Countries (Days)

International Classification of Disease categories	United States	United Kingdom	Canada	France	Switzerland
Pulmonary tuberculosis	13.9	19.6	32.6	20.3	32.5
Malignant neoplasm of trachea, bronchus and lung	8.8	11.4	17.8	13.8	16.1
Breast cancer	7.1	12.0	14.5	7.0	19.3
Prostate cancer	7.2	13.0	17.0	12.7	18.4
Diabetes mellitus	7.6	17.9	17.2	12.6	25.6
Alcoholic psychoses	NA	NA	19.4	17.0	19.6
Alcohol dependence syndrome	10.7	8.6	11.4	12.3	13.6
Inflammatory disease of the eye	3.9	5.7	4.3	7.0	11.1
Cataract	1.7	6.4	4.0	8.4	11.1
Otitis	2.6	7.7	3.1	5.2	6.4
Rheumatic fever	9.1	11.8	13.3	12.6	16.3
Hypertension	5.6	13.5	13.5	10.2	19.6
Acute myocardial infarction	8.9	11.2	14.7	12.8	17.8
Pneumonia	7.8	39.9	16.8	13.4	16.9
Pneumococcal pneumonia	7.7	15.7	11.4	14.5	17.9
Bronchitis	3.6	15.8	8.7	13.2	18.7
Asthma	4.8	4.9	5.5	8.3	14.4
Ulcers of stomach/small intestine	7.1	10.7	10.5	13.1	14.1
Appendicitis	4.8	5.6	5.5	7.6	8.5
Hernia of abdominal cavity	3.0	5.5	5.5	6.0	NA
Cholelithiasis	6.9	9.9	9.2	11.5	14.2
Nephritis	11.0	11.7	13.1	11.0	17.6
Calculus of kidney and ureter	3.6	7.4	6.0	7.1	7.3
Cystitis	6.0	3.8	6.9	8.2	10.4
Normal delivery	2.4	4.3	4.2	6.3	8.5
Major puerperal infection	4.3	4.4	4.9	9.3	6.8
Infections of the skin	7.3	8.1	7.2	5.2	10.1
Other inflammatory diseases of skin	6.7	9.4	12.0	13.9	15.2
Osteoarthrosis	10.2	25.7	19.9	17.5	22.2
Intervertebral disc disorders	6.9	12.0	9.7	11.2	17.9
Respiratory distress syndrome	23.6	19.7	18.5	19.2	11.5
Hemolytic diseases and jaundice	7.0	6.7	3.7	7.4	7.4
Fracture of neck of femur	14.2	29.7	32.9	18.9	33.6
Sprains and strains of back	5.6	5.9	5.7	9.8	9.4

NOTE: Most current data for United States, France and Switzerland are from 1986. United Kingdom and Canadian data are from 1985.

SOURCE: Organization for Economic Cooperation and Development, Health Data File, 1989.

Table 5.8

Estimate and Projections of Active Physicians and Dentists (1950–2000) (Thousands)

	Physicians			
Year	**Total**	**Medical doctors**	**Osteopaths**	**Dentists**
Actual				
1950	219.9	209.0	10.9	79.2
1955	240.2	228.6	11.6	84.4
1960	259.5	247.3	12.2	90.1
1965	288.7	277.6	11.1	96.0
1970	326.2	314.2	12.0	102.2
1975	384.4	370.4	14.0	112.0
1980	457.5	440.4	17.1	126.2
1981	466.7	448.7	18.0	129.2
1982	483.7	465.0	18.7	132.0
1983	501.2	481.5	19.7	135.1
1984	506.5	485.7	20.8	138.0
1985	520.7	498.8	21.9	140.8
1986	534.8	511.6	23.2	143.2
1987	548.5	524.1	24.4	145.5
1988	562.0	536.3	25.7	147.4
Projections				
1990	587.7	559.5	28.2	150.8
1995	645.5	611.1	34.4	156.8
2000	696.5	656.1	40.0	161.2

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration.

Table 5.9

Community Hospitals, Beds, Admissions and Occupancy (1972–1988)

Year	Hospital	Beds (thousands)	Admissions (in thousands)	Occupancy (percent)
1972	5,746	879	30,709	75.4
1973	5,789	898	31,671	75.7
1974	5,875	926	32,866	75.6
1975	5,875	942	33,435	75.0
1976	5,857	956	33,979	74.6
1977	5,881	969	34,273	73.8
1978	5,851	975	34,506	73.6
1979	5,842	984	35,099	73.9
1980	5,830	988	36,143	75.6
1981	5,813	1,003	36,438	76.0
1982	5,801	1,012	36,379	75.3
1983	5,783	1,018	36,152	73.5
1984	5,759	1,017	35,155	69.0
1985	5,732	1,001	33,449	64.8
1986	5,678	978	32,379	64.3
1987	5,611	958	31,601	64.9
1988	5,533	947	31,453	65.5

SOURCE: American Hospital Association. Hospital Statistics, 1989–1990.

Table 5.10

Organ Transplants in the United States (1988–1989)

Type	Number of transplants	Persons waiting for transplant (July 1990)
Total	**13,290**	**20,958**
Kidney	8,886	17,445
Heart	1,673	1,686
Liver	2,160	996
Pancreas	412	387
Heart-Lung	70	258
Lung	89	186

SOURCE: United Network for Organ Sharing, Richmond, Virginia.

Chapter 6

DISABILITY, MORBIDITY AND MORTALITY

◆ Disability

Disability income insurance is a form of health insurance provided by group and individual policies, and by specific government programs designed to replace income for insured persons who become disabled and are unable to work because of illness, injury or disease. Disability rates for both acute and chronic health conditions as measured by work-loss days, restricted activity days and disability days vary by social and economic characteristics.

Occupational Illnesses and Injuries

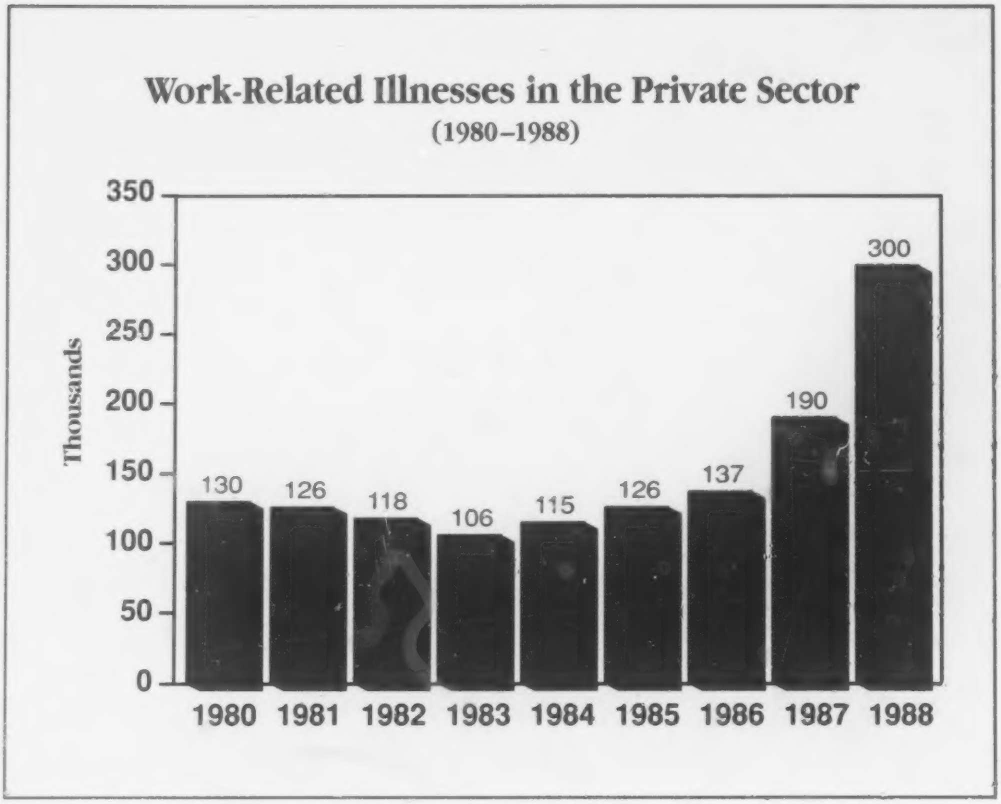
The Bureau of Labor Statistics annual survey of occupational injuries and illnesses in 1988 reported that there were more than 240,900 new cases of occupational illnesses among workers in 1988, a 25 percent increase from 1987. Manufacturing workers reported nearly three-fourths of the total new cases of illness in 1988, which included illness and disorders associated with repeated trauma and conditions due to repeated motion, pressure or vibration, such as carpal tunnel syndrome.

Repeated traumas constituted almost 50 percent of the illness cases in 1988, while skin diseases accounted for 25 percent of the total.

Approximately 350,000 more job-related injuries were reported in the private sector in 1988 than in 1987. The private sector incidence rate was 8.3 per 100 full-time workers in 1988 compared to 8.0 in 1987.

The probability of a male becoming temporarily or permanently disabled between the ages of 20 and 30 is 1.3 percent, but between the ages of 20 and 60 this increases to 19.1 percent. (Table 6.1) Females are less prone to disability during their lifetimes and have only a 15.3 percent chance of becoming disabled between 20 and 60 years of age. These data are based on males and females who turned 20 years old in 1986.

Table 6.2 shows that workers with higher incomes have fewer days of disability from acute health conditions. Marked differences in the number of disabil-



SOURCE: U.S. Department of Labor.

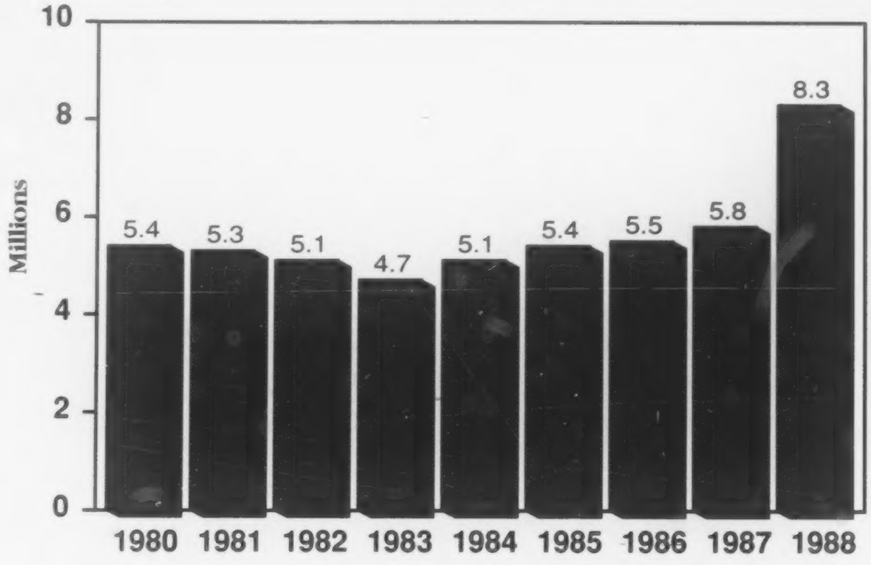
ity days are also found in relation to the sex of the worker. Females averaged 9.8 days and males averaged only 7.7 days of restricted activity per person in 1988.

Acute Conditions

Some 358 million workdays were lost as a result of all acute health conditions in 1988, a 3 percent increase over 1987 (Table 6.3). This was an average of 3.1 days off the job for each worker in the metropolitan statistical areas of the nation. Men were more often unable to work due to injuries, and women lost more workdays due to respiratory infections.

Chronic Conditions

In 1988, 34 million persons, 14 percent of the U.S. civilian noninstitutionalized population (243.1 million), suffered some activity limitation because of one or more chronic conditions. Chronic conditions and long-term latent illnesses often are difficult to recognize and are not recorded adequately.



Work-Related Injuries in the Private Sector
(1980–1988)

SOURCE: U.S. Department of Labor.

◆ Social Security Disability Insurance Program

The Social Security Disability Insurance Program is the largest federal income program for disabled persons. Table 6.6 shows the growth of this program from 1965 to 1988.

The number of workers and dependents receiving benefits through Social Security peaked in 1978 and generally has declined since. In 1988, 4.1 million disabled workers received a total of $22.1 billion in benefits through the program.

◆ Morbidity and Mortality

Despite medical breakthroughs and environmental changes, cardiovascular-renal diseases and cancer are still the leading causes of death in the United States. Deaths from cancer increased slightly in 1987 to 22.4 percent while deaths from heart diseases and related illnesses continued to decrease, as they have since 1960.

Life expectancy at birth increased slightly for males to 71.5 years, and remained the same for females at 78.3 years in 1987. (Table 6.7)

The death rate in the United States has been affected in the past few years by acquired immune deficiency syndrome (AIDS). The AIDS epidemic ranks as one of the nation's worst public health disasters. In 1989, the Centers for Disease Control in Atlanta reported 26,000 new cases and 16,229 deaths. (Table 6.8) It is estimated by CDC that 1.5 million Americans are infected with the AIDS virus.

Although the overall crude death rate in the United States has decreased generally over the years, it remained the same (8.7 per 1,000 population) in 1988 as it was in 1987.

The downward trend in the mortality rate is in part the result of a decline in the incidence of heart and cardiovascular disease. Mortality rates for these two causes decreased 7.3 percent from 1982 to 1988.

Table 6.1

Probability of Disability or Dying between Age 20 and Attained Age for Workers Eligible for Social Security Income (1986)

From age 20 to age	Probability of insured disability from age 20	
	Males	Females
21	0.1%	0.0%
25	0.5	0.3
30	1.3	0.7
35	2.3	1.5
40	3.5	2.6
45	5.2	4.1
50	7.8	6.4
55	12.0	9.9
60	19.1	15.3
65	29.2	22.1
66	30.8	23.1
67	32.2	24.0

SOURCE: U.S. Department of Health and Human Services, Social Security Administration.

Table 6.2

Disability Days Due to Acute Conditions by Social and Economic Characteristics (1987–1988)

	Restricted activity		Bed disability		Work loss 18 years or more	
	1987	1988	1987	1988	1987	1988
Sex						
Male	6.1	6.9	2.5	2.4	2.8	2.7
Female	7.7	9.8	3.4	3.5	3.4	2.7
Family income						
Under $10,000	9.1	10.0	4.4	4.7	4.1	3.8
$10,000–19,999	7.3	7.7	3.3	3.4	NA	NA
$20,000–34,999	6.8	6.5	2.8	2.7	NA	NA
$35,000 and more	5.8	5.8	2.4	2.4	2.4	NA
Place of residence						
Metropolitan	6.7	6.8	3.1	3.0	3.1	3.1
Other	7.1	7.3	3.0	3.0	3.0	3.1
Age						
Under 5 years	9.4	9.7	4.4	4.9	NA	NA
5–17 years	6.5	7.2	2.9	3.4	NA	NA
18–24 years	6.9	7.1	3.0	3.0	3.4	3.5
25–44 years	6.3	6.4	2.7	2.5	3.1	3.2
45–66 years	6.1	5.8	2.6	2.4	2.9	2.5
65 years and more	8.1	8.1	3.4	3.4	NA	NA

NOTES: The data refer to the civilian, noninstitutionalized population. A restricted activity day is one on which a person cuts down on his or her usual activities for the whole day because of illness or injury. A bed disability day is one on which a person stays in bed for all or most of the day because of a specific illness or injury. Family income includes the total income of each member of the family.

SOURCE: U.S. Department of Health and Human Services, National Center for Health Statistics, Current Estimates from the National Health Interview Survey, United States, 1988.

Table 6.3

Workdays Lost Due to Acute Conditions (1987–1988)

	Number of work-loss days (millions)						Work-loss days per employed person					
	All ages 18 and more		Age 18 to 44		Age 45 and more		All ages 18 and more		Ages 18 to 44		Age 45 and more	
Both sexes	1987	1988	1987	1988	1987	1988	1987	1988	1987	1988	1987	1988
All acute conditions	347	358	252	271	95	87	3.1	3.1	3.2	3.3	2.9	2.5
Infectious/parasitic diseases	25	29	22	25	3	3	0.8	0.2	0.3	0.3	0.3	0.1
Respiratory conditions	111	127	81	94	30	32	1.1	1.1	1.1	1.1	1.1	1
Digestive system conditions	16	14	12	11	3	2	0.2	0.1	2.1	0.2	0.2	0.1
Injuries	119	109	85	81	34	27	1.1	0.1	1.1	1	1	1
All other acute conditions	18	21	11	11	17	9	0.2	0.2	0.1	0.1	0.1	0.2
Male												
All acute conditions	175	175	124	130	51	45	2.8	2.7	2.9	2.9	2.7	2.3
Infectious/parasitic diseases	10	13	9	11	0.9	1	0.2	0.2	0.2	0.2	0.1	0.1
Respiratory conditions	54	58	39	42	15	15	0.8	0.9	0.9	0.9	0.7	0.8
Digestive system conditions	8	7	6	6	3	1	0.2	0.1	0.1	0.1	0.2	0.1
Injuries	77	74	57	57	20	17	1.2	1.1	1.4	1.2	1.1	0.9
All other acute conditions	8	9	5	5	3	4	0.2	0.1	0.1	0.1	0.2	0.2
Female												
All acute conditions	172	183	128	141	44	42	3.4	3.5	4	3.8	3.1	2.8
Infectious/parasitic diseases	15	15	13	13	2	2	0.3	0.2	0.4	0.3	0.2	0.1
Respiratory conditions	57	69	42	52	15	17	1.4	1.3	1.2	1.4	1.1	1.1
Digestive system conditions	7	7	7	5	0.8	1	0.2	0.1	0.2	0.1	0.2	0.1
Injuries	42	35	28	24	14	10	0.8	0.6	0.5	0.6	1	0.7
All other acute conditions	9	11	6	6	4	4	0.2	0.2	0.2	0.1	0.3	0.3

NOTES: The data refer to the civilian noninstitutionalized population. An acute condition is one that lasted fewer than 3 months and that involved either medical attention or restricted activity. A "work-loss" day is a day on which a currently employed person, 18 years of age and more, did not work at least half of his or her normal workday because of a specific illness or injury. In some cases the sum of the items does not equal the total shown because of rounding.

SOURCE: U.S. Department of Health and Human Services, National Center for Health Statistics, Current Estimates from the National Health Interview Survey, United States, 1987.

Table 6.4

Number of Occupational Injuries and Illnesses and Lost Workdays, Private Sector by Industry Division (1987–1988)

(Thousands)

	Total cases*		Cases with lost workdays		Lost workdays	
	1987	1988	1987	1988	1987	1988
Injuries and illnesses						
Private sector**	6,035.9	6,438.6	2,801.6	2,975.9	50,941.4	56,945.9
Agriculture, forestry and fishing**	99.6	101.9	50.8	52.7	837.7	952.1
Mining	61.5	64.4	35.1	37.7	1,039.5	1,113.2
Construction	638.6	656.5	295.0	307.8	5,895.3	6,396.8
Manufacturing	2,212.6	2,464.8	976.5	1,079.2	17,689.9	20,254.7
Durable goods	1,385.6	1,601.7	597.0	671.2	10,699.2	12,538.9
Nondurable goods	827.0	863.1	379.5	408.0	6,990.7	7,715.8
Transportation and public utilities	429.2	464.8	250.6	264.6	5,497.2	6,165.6
Wholesale and retail trade	1,470.5	1,534.8	654.8	684.0	10,725.2	11,933.3
Wholesale trade	408.7	432.9	205.4	216.9	3,525.7	3,915.8
Retail trade	1,061.8	1,101.9	449.4	467.1	7,199.4	8,017.5
Finance, insurance and real estate	115.3	119.4	51.2	55.6	832.9	1,022.6
Services	1,009.0	1,031.9	487.5	494.3	8,423.6	9,104.6
Injuries						
Private sector**	5,845.5	6,197.7	2,721.3	2,878.4	49,069.6	54,286.8
Agriculture, forestry and fishing**	95.0	97.3	49.3	51.3	823.4	933.2
Mining	59.3	62.5	34.6	37.1	1,028.9	1,100.3
Construction	631.2	649.6	292.3	304.9	5,854.2	6,353.7
Manufacturing	2,087.2	2,288.0	923.2	1,006.9	16,293.7	18,183.5
Durable goods	1,306.9	1,483.8	565.7	626.7	9,869.2	11,222.2
Nondurable goods	780.3	804.2	357.5	380.2	6,424.6	6,961.2
Transportation and public utilities	422.5	455.8	247.5	261.3	5,442.7	6,097.9
Wholesale and retail trade	1,456.2	1,519.5	648.3	676.9	10,592.8	11,708.1
Wholesale trade	403.8	426.6	203.3	214.0	3,485.0	3,857.0
Retail trade	1,052.4	1,092.9	445.0	462.9	7,107.7	7,851.1
Finance, insurance and real estate	112.2	116.3	49.9	54.0	802.8	968.3
Services	981.9	1,008.6	476.0	485.9	8,231.1	8,941.8
Illnesses						
Private sector**	190.4	240.9	80.3	97.5	1,871.7	2,656.1
Agriculture, forestry and fishing**	4.6	4.6	1.5	1.4	14.4	18.9
Mining	2.2	1.9	0.5	0.6	10.6	12.9
Construction	7.0	6.9	2.7	2.8	41.1	43.0
Manufacturing	125.4	176.7	53.3	72.3	1,396.2	2,071.2
Durable goods	78.7	117.9	31.3	44.5	830.0	1,316.7
Nondurable goods	46.7	58.9	22.0	27.8	566.2	754.6
Transportation and public utilities	6.7	9.0	3.1	3.3	54.5	67.7
Wholesale and retail trade	14.3	15.3	6.5	7.1	132.4	225.2
Wholesale trade	4.8	6.3	2.1	2.9	40.7	58.8
Retail trade	9.5	9.0	4.4	4.1	91.7	166.4
Finance, insurance and real estate	3.1	3.1	1.2	1.6	30.1	54.3
Services	27.1	23.3	11.6	8.4	192.5	162.8

*Includes fatalities.

** Excludes farms with fewer than 11 employees.

NOTES: Because of rounding, components may not add to the totals. The difference between the number of total cases and the sum of the lost workdays cases and nonfatal cases without lost workdays may not equal the fatalities.

SOURCE: U.S. Department of Labor, Bureau of Labor Statistics.

Table 6.5

Occupational Injury and Illness Incidence Rates Per 100 Full-Time Employees

Year	Total cases	Cases with lost workdays	Nonfatal cases without lost workdays	Lost workdays
1980	8.7	4.0	4.7	65.2
1981	8.3	3.8	4.5	61.7
1982	7.7	3.5	4.2	58.7
1983	7.6	3.4	4.2	58.5
1984	4.0	3.7	4.3	63.4
1985	7.9	3.6	4.3	64.9
1986	7.9	3.6	4.3	65.8
1987	8.3	3.8	4.4	69.9
1988	8.6	4.0	4.6	76.1

SOURCE: U.S. Department of Labor, Bureau of Labor Statistics, Occupational Injuries and Illnesses in 1988, November 15, 1989.

Table 6.6

Growth in the Social Security Disability Program (1965–1988)

Year	Number of workers insured for disability (millions)	Number of workers receiving benefits (millions)	Number per 100,000 insured workers	Total disability insurance beneficiaries (millions)	Total cash benefits paid for disability (billions)
1965	53.3	1.1	1,954	1.7	1.6
1966	55.0	1.1	1,995	1.9	1.8
1967	55.7	1.2	2,142	2.1	1.9
1968	56.9	1.3	2,276	2.3	2.3
1969	70.1	1.4	1,989	2.5	2.5
1970	72.4	1.5	2,062	2.7	3.1
1971	74.5	1.6	2,212	2.9	3.8
1972	76.1	1.8	2,409	3.3	4.5
1973	77.8	2.1	2,592	3.6	5.7
1974	80.4	2.2	2,782	3.9	6.9
1975	83.3	2.5	2,988	4.5	8.4
1976	85.3	2.7	3,130	4.6	10.1
1977	87.0	2.8	3,261	4.9	11.5
1978	89.3	2.9	3,225	4.9	12.5
1979	93.7	2.9	3,064	4.8	13.7
1980	98.0	2.9	2,9[illegible]7	4.7	15.4
1981	100.5	2.8	2,763	4.5	17.2
1982	102.4	2.6	2,543	3.9	17.3
1983	103.6	2.6	2,480	3.8	17.5
1984	106.6	2.6	2,436	3.8	17.9
1985	109.2	2.7	2,433	3.9	18.8
1986	111.3	2.8	2,450	3.9	19.9
1987	113.3	2.8	2,458	4.1	20.5
1988	115.3	2.8	2,556	4.1	22.1

NOTE: Number of disabled workers in current status as of December 31 of the year indicated. Insured workers as of January 1 of the year indicated.
SOURCE: U.S. Department of Health and Human Services, Social Security Administration.

Table 6.7

Life Expectancy at Birth and at 65 Years of Age

Year of birth	All races Male	All races Female	White Male	White Female	Black Male	Black Female
	70.0	77.4	70.7	78.1	63.8	72.5
1980	70.4	77.8	71.1	78.4	64.5	73.2
1981	70.9	78.1	71.5	78.7	65.1	73.7
1982	71.0	78.1	71.7	78.7	65.4	73.6
1983	71.2	78.2	71.8	78.7	65.6	73.7
1984	71.2	78.2	71.9	78.7	65.3	73.5
1986	71.3	78.3	72.0	78.8	65.2	73.5
1987*	71.5	78.3	72.1	78.8	65.4	73.8
At 65 years old in						
1980	14.1	18.3	14.2	18.4	13.0	16.8
1981	14.3	18.6	14.4	18.7	13.4	17.3
1982	14.5	18.7	14.5	18.8	13.5	17.5
1983	14.5	18.6	14.5	18.7	13.4	17.3
1984	14.6	18.6	14.6	18.7	13.5	17.2
1985	14.6	18.6	14.6	18.7	13.3	17.0
1986	14.7	18.6	14.6	18.7	13.4	17.0
1987*	14.8	18.6	14.9	18.7	13.6	17.2

*Provisional data.

SOURCE: National Center for Health Statistics, Advancedata 1988.

Table 6.8

AIDS Cases by Cases and Deaths before 1981 through December 1989

Year of diagnosis	Adults and adolescents Cases	Adults and adolescents Deaths	Children under 13 years Cases	Children under 13 years Deaths
Total	**119,950**	**71,465**	**2,055**	**1,113**
Before 1981	77	30	6	1
1981	287	121	13	8
1982	1,048	428	27	13
1983	2,864	1,408	73	29
1984	5,823	3,257	109	48
1985	10,843	6,374	224	111
1986	17,545	10,929	295	146
1987	25,749	14,454	449	264
1988	29,714	18,008	488	268
1989	25,522	16,229	370	220

SOURCE: U.S. Department of Health and Human Services, Centers for Disease Control, HIV/AIDS Surveillance Report, February 1990.

Table 6.9

The 10 Most Common Causes of Death (1987)

Cause of death	Death rate*
Diseases of the heart	312.4
Malignant neoplasms	195.9
Cerebrovascular disease	61.6
Accidents and adverse effects	39.0
Chronic obstructive pulmonary diseases and allied conditions	32.2
Influenza	28.4
Diabetes mellitus	15.8
Suicide	12.7
Chronic liver disease and cirrhosis	10.8
Atherosclerosis	9.2
All other causes	154.3

*NOTE: Deaths per 100,000 population.

SOURCE: National Center for Health Statistics, Monthly Vital Statistics Report, September 26, 1989.

Table 6.10

Death Rates for the Four Leading Causes of Death by State (1987) (Per 100,000 residents)

	Heart	Cancer	Stroke	Accident
Northeast				
Maine	349.7	226.9	64.9	33.9
New Hampshire	280.0	187.9	57.9	31.8
Vermont	304.7	195.3	57.3	40.0
Massachusetts	343.7	226.8	64.5	29.5
Rhode Island	367.7	231.4	61.2	31.8
Connecticut	319.0	215.0	54.5	30.5
New York	378.1	215.4	54.9	32.6
New Jersey	351.3	223.7	58.1	31.6
Pennsylvania	398.3	241.8	67.4	37.6
North Central				
Ohio	348.1	212.6	62.2	33.8
Indiana	322.9	199.9	69.0	38.7
Illinois	336.8	200.1	59.6	33.1
Michigan	331.2	191.8	59.5	34.2
Wisconsin	326.9	196.5	70.6	34.4
Minnesota	278.8	181.5	68.0	34.6
Iowa	366.8	208.3	77.0	37.2
Missouri	360.7	218.1	74.4	42.2
North Dakota	290.0	187.2	70.2	35.1
South Dakota	355.4	192.7	68.0	44.4
Nebraska	346.4	192.9	70.1	40.2
Kansas	320.8	186.9	66.3	41.4
South				
Delaware	318.6	211.3	45.5	41.3
Maryland	289.2	200.8	51.3	35.3
District of Columbia	346.5	262.5	62.7	33.8
Virginia	271.0	182.9	58.3	38.9
West Virginia	406.8	225.1	69.8	49.5
North Carolina	304.0	189.2	70.5	48.2
South Carolina	288.0	172.2	74.6	56.4
Georgia	267.5	170.0	64.8	47.5
Florida	382.5	250.9	74.5	42.7
Kentucky	339.6	204.9	71.0	46.4
Tennessee	326.5	205.5	77.8	48.1
Alabama	321.8	204.5	72.5	52.9
Mississippi	348.0	192.8	71.4	57.7
Arkansas	366.5	223.3	86.6	53.4
Louisiana	292.6	182.1	56.3	41.2
Oklahoma	325.3	195.0	73.0	41.9
Texas	238.3	150.7	48.8	38.1
West				
Montana	262.7	185.7	53.8	52.4
Idaho	235.7	154.4	58.9	45.7
Wyoming	193.7	138.8	41.4	41.4
Colorado	193.1	133.3	40.6	37.2
New Mexico	192.9	141.7	38.6	54.3
Arizona	255.4	181.7	44.9	50.8

Continued

Utah	176.3	99.2	39.4	34.3
Nevada	255.1	190.3	41.1	38.8
Washington	255.0	179.5	57.9	38.2
Oregon	294.6	203.4	71.7	45.9
California	250.4	171.2	56.8	38.1
Alaska	91.6	84.2	16.8	61.0
Hawaii	184.3	131.9	42.7	28.7

SOURCE: National Center for Health Statistics, Monthly Vital Statistics Report, September 26, 1989.

Table 6.11

Trends in Death Rates (1920–1987)

Death rates and causes (per 100,000 population)	1920	1940	1960	1980	1987
Death rates	1,298.9	1,076.4	954.7	874.1	872.4
Major causes of death					
Pneumonia and influenza	207.3	70.3	37.3	23.2	28.4
Diseases of the heart	159.6	292.5	369.0	335.9	312.4
Tuberculosis	113.1	45.9	6.1	*	*
Cerebrovascular diseases	93.0	90.9	108.0	75.0	61.6
Malignant neoplasms	83.4	120.3	149.2	182.4	195.9
Accidents	71.0	73.6	52.3	46.9	39.0
Infant mortality (per 1,000 live births)	NA	47.0	26.0	12.5	10.1
Maternal mortality (per 100,000 live births)	NA	376.0	37.1	6.9	6.6

*Not listed as a major cause of death.

SOURCE: National Center for Health Statistics, Monthly Vital Statistics Report, September 26, 1989.

HEALTH AND HEALTH CARE ACRONYMS

ACLI	American Council of Life Insurance
ADA	American Dental Association
AD&D	Accidental Death & Dismemberment Policy
AHA	American Hospital Association
AIDS	Acquired Immune Deficiency Syndrome
AMA	American Medical Association
ANA	American Nurses Association
APA	American Pharmaceutical Association
ASO	Administrative Services Only
BCBS	Blue Cross-Blue Shield
BLS	Bureau of Labor Statistics
CDC	Centers for Disease Control
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
COB	Coordination of Benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act
CON	Certificate of Need
CPI	Consumer Price Index
CPR	Cardiopulmonary Resuscitation
CPT	Current Procedural Terminology
DOL	Department of Labor
DRG	Diagnosis-Related Group
EBRI	Employee Benefit Research Institute
EOB	Explanation of Benefits
EPO	Exclusive Provider Organization
ERISA	Employee Retirement Income Security Act
FEHBP	Federal Employees Health Benefits Program
FFS	Fee for Service
GAO	General Accounting Office
GDP	Gross Domestic Product
GHAA	Group Health Association of America
GNP	Gross National Product
HCFA	Health Care Financing Administration
HCPCS	HCFA Common Procedural Coding System

HHS	Health and Human Services, U.S. Department of
HIAA	Health Insurance Association of America
HIV	Human Immunosuppressant Virus
HMO	Health Maintenance Organization
ICD	International Classification of Diseases
IPA	Independent Practice Association
LHD	Local Health Departments
LOS	Length of Stay
LTC	Long-Term Care
LTD	Long-Term Disability
MMPS	Medical Mortality Prediction System
MPP	Minimum Premium Plan
NAHDO	National Association of Health Data Organizations
NAIC	National Association of Insurance Commissioners
NCHS	National Center for Health Statistics
NCHSR	National Center for Health Services Research
NHC	National Health Council
NIH	National Institutes of Health
NIMH	National Institute of Mental Health
OECD	Organization for Economic Cooperation and Development
PPO	Preferred Provider Organization
PPS	Prospective Payment System
ProPAC	Prospective Payment Review Assessment Commission
SHA	State Health Agency
SNF	Skilled Nursing Facility
SSA	Social Security Administration
STD	Sexually Transmitted Disease
STD	Short-Term Disability
TEFRA	Tax Equity and Fiscal Responsibility Act
TPA	Third-Party Administrator
TPP	Third-Party Payer
UCR	Usual, Customary and Reasonable
UR	Utilization Review
WHO	World Health Organization

HISTORICAL INSURANCE FACTS

1798	U.S. Marine Hospital Service established by U.S. Congress. Compulsory deductions for hospital service were made from seamen's wages.
1847	The first insurer to issue sickness insurance was organized: The Massachusetts Health Insurance Company of Boston.
1849	New York State passed the first general insurance law.
1850s	The first insurance supervisory boards were created in New Hampshire, Massachusetts, Rhode Island and Vermont.
1850	Individual accident insurance became available in the United States with the chartering of the Franklin Health Assurance Company in Massachusetts.
1851	One of the earliest voluntary mutual protection associations, *La Société Française de Bienfaisance Mutuelle*, was organized in San Francisco. It is noteworthy for having established a hospital in 1852 to provide for its members.
1855	The first separate insurance department, independent of any established agency, was created in Massachusetts.
1859	The first full-time insurance commissioner was appointed in New York.
1863	The Travelers Insurance Company of Hartford, Connecticut, offered accident insurance for railway mishaps; then, all forms of accident protection. It was the first company to issue insurance on a basis resembling its present form.
1875	A number of mutual benefit associations, called "establishment funds," were formed for employees of a single employer. The benefits provided usually included small payments for death and disability.
1890s	This period brought the promotion of many fraternal associations, assessment mutuals and industrial insurers. Because many of these companies and associations were inadequately financed and poorly managed, many states passed legislation against them.
1890	Policies providing benefits for disability from specified diseases were first offered.
1900	Shortly after the turn of the century, disability benefits became available for substantially all diseases.
1910	Montgomery Ward & Co., Inc., replaced its "employee establishment fund" with an insured contract. This plan is generally regarded as the first group health insurance policy.
1912	The Standard Provisions Law drafted by the National Convention of Insurance Commissioners (now the NAIC) was

enacted by most states. This model law sought to provide uniformity and fairness in the "operating conditions" of the health insurance contract.

1916 First noncancelable disability income contract was offered.

1917 Group accidental death and dismemberment insurance was first written.

1920s Early in this decade individual hospitals began offering hospital expense benefits on an individual prepaid basis.

1920s First partial disability benefits for sickness and accident became available.

1929 The first health maintenance organization, the Ross-Loos Clinic, was established in Los Angeles, California.

1929 A group of school teachers arranged for Baylor Hospital in Dallas, Texas, to provide room and board and specified ancillary services at a predetermined monthly cost. This plan is considered the forerunner of what later became known as the Blue Cross plans.

1929 With the Depression, many companies entered a period of retrenchment in their disability income product line, particularly in the area of maintaining reasonable indemnity limits in order to avoid overinsurance.

1930s The Depression stimulated the expansion of insurance coverages through both public demand and hospitals' encouragement.

1932 First citywide Blue Cross plan was tried out with a group of hospitals in Sacramento, California.

1935 The Social Security Act (P.L. 74-241) provided for the first time grant-in-aid to states for such public health activities as maternal and child care, aid to crippled children, blind persons, the aged and other health-impaired persons.

1937 Health Service Plan Commission (Blue Cross Commission) was organized.

1938 Hospital insurance for dependents of covered persons was developed.

1938 Private insurers introduced group surgical expense benefit plans.

1939 The first Blue Shield plan (surgical-medical), called the California Physicians' Service, was developed.

1940s During World War II, as a result of the freezing of wages, group health insurance became an important component of collective bargaining for employee benefits.

1942 Compulsory cash sickness benefits were begun by four states (Rhode Island, 1942; California, 1946; New Jersey, 1948; New York, 1949).

1943 Private insurers introduced group medical expense benefits (physicians' visits expense benefits).

1946 The Health Insurance Council, a federation of eight insurance associations organized to give technical and practical assistance on health insurance to the providers of medical care, was formed.

1946 Blue Shield Medical Care Plans, Inc. (Blue Shield Commission) was organized.

1948 The National Labor Relations Board ruled, in a dispute between the United Steelworkers' Union and the Inland Steel Company, that the term "wages" be construed to include pension and insurance benefits. The U.S. Supreme Court upheld this ruling in a 1949 decision.

1949 Major medical expense benefits were introduced by Liberty Mutual Insurance Company to supplement basic medical care expenses.

1954 Congress introduced the disability "freeze" that stated that the quarters during which a worker is disabled are not counted in determining the number of quarters needed to be fully or currently insured under Old Age and Survivors Insurance (OASI).

1956 Disability insurance was added to the Social Security System, providing monthly cash benefits for insured persons who are totally disabled.

1957 Vision care expense benefits were introduced by private insurers, followed in 1959 by extended care facility expense benefits.

1959 Continental Casualty Company issued the first comprehensive group dental insurance plan written by an insurance company.

1960s First disability contracts for business use appeared (overhead expense, key man).

1960s Eligibility for disability benefits under Social Security was expanded.

1961 First state enrollment plan was made available by Connecticut to persons aged 65 and more on a state basis and under special enabling legislation allowing the pooling of risks by a group of insurance companies (Associated Connecticut Health Insurance Companies).

1963 The Health Profession Educational Assistance Act (P.L. 88-129) aided training of physicians, dentists and other public health personnel.

1964 Prescription drug expense benefits were introduced.

1964 The Nurse Training Act (P.L. 88-581) provided special federal effort for training professional nursing personnel.

1965 Social Security Amendments of 1965 (P.L. 89-97) established a Social Security hospital insurance program for the aged and voluntary supplementary medical insurance program (Medicare) and grants to states for medical assistance programs (Medicaid).

1966 Program of governmental health insurance, Medicare, for people aged 65 and more, became effective July 1.

1967 The Age Discrimination in Employment Act (DEA) became effective.
- The act applied only to employees between the ages of 40 and 65, and the vast majority of employee benefit plans provided them with the same benefits as younger employees.
- The act contained a specific provision (Section 4(f)(2)) which stated that it was permissible for an employer to observe the terms of any bona fide employee benefit plan such as a retirement, pension or insurance plan which was not a subterfuge to evade the purposes of the act.

1971 The Insurance Medical Scientist Scholarship Fund was formed by several insurance companies, providing full scholarships for students planning careers in medical research and teaching.

1972 Social Security Amendments of 1972 (P.L. 92-603) extended health insurance benefits (Medicare) to the disabled and to end-stage renal disease patients, established Professional Standards Review Organization (PSRO) programs, expanded research and demonstrations of financing mechanisms and introduced automatic cost-of-living adjustments to disability benefits.

1972 Legislation created the Supplemental Security Income program, which federalized categorical public assistance for the aged, blind and permanently and totally disabled.

1973 The Health Maintenance Organization Act (P.L. 93-222) assisted in the establishment and expansion of HMOs.

1974 Employee Retirement Income Security Act (ERISA) of 1974 was signed into law. While generally thought of as a law that regulates private pension plans, the act also contains provisions relating to other employee benefit plans that have encouraged the growth of self-insurance.

1975 The National Health Planning and Resources Development Act of 1974 (P.L. 93-641) authorized major federal reorganization of health planning programs and set up the national designation of local Health Systems Areas and governing agencies.

1976 The Health Professions Educational Assistance Act of 1976 (P.L. 94-484) contained provisions requiring medical school students who receive federal scholarship aid to serve a specified period in rural and inner city areas, and required that medical schools with teaching hospitals provide for a greater proportion of medical residencies in primary medicine.

1976 The Health Maintenance Organization Amendments of 1976 (P.L. 94-460) relaxed requirements for HMOs to qualify for federal support.

1976 The National Consumer Health Information and Health Promotion Act of 1976 (P.L. 94-317) set forth national goals for health information and promotion and a systematic strategy for their achievement, stressing health education.

1977 The Medicare-Medicaid Anti-Fraud and Abuse Amendments (P.L. 95-142) amended the Social Security Act to require uniform reporting of financial data by providers, upgraded criminal penalties for fraud under Medicare-Medicaid programs and amended certain Professional Standards Review Organization (PSRO) provisions.

1978 The Health Maintenance Organization Amendments of 1978 (P.L. 95-559) set forth a three-year extension of the HMO assistance program.

1978 Title VII of the Civil Rights Act of 1964 was amended to prohibit sex discrimination on the basis of pregnancy for all employment-related purposes.

1978 ADEA of 1967 was amended to raise the mandatory retirement age from 65 to 70. The act prohibits discrimination concerning benefits to older workers. An employer may coordinate benefits with other programs—e.g., Medicare for employees over age 65—provided that total benefits are equivalent to those offered younger workers.

1981 The Omnibus Budget Reconciliation Act mandated significant cuts in federal expenditures for health programs, increased Medicare deductibles, removed the limit on the number of states that can apply for Medicare and Medicaid cost reimbursement waivers and directed the Secretary of HHS to develop a model prospective reimbursement methodology for inpatient services under Medicare and Medicaid.

1982 Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 provided Medicare recognition for any state hospital cost-control system that meets certain federal standards (including equitable treatment of all payers) and for employees aged 65–69 with employer-sponsored health insurance. It made Medicare the secondary payer, brought federal employees under Medicare and made certain changes in the methods of hospital reimbursements under Medicare.

1983 In response to the requirement of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, a prospective payment system for hospital care of Medicare enrollees was enacted as a component of the Social Security Amendments of 1983.

1984 Omnibus Deficit Reduction Act of 1984 (P.L. 98-369) extended Medicare as secondary payer of aged spouses of workers under age 65, froze Medicare reimbursement for physician fees and reduced increases in hospital costs.

1984 National Organ Transplant Act of 1984 (P.L. 98-507) established a task force on organ transplantation, authorized grants for organ procurement organizations and established bone marrow registry demonstration and study.

1985 Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272) required that employer group health plans offer continued coverage to workers and their dependents upon termination of employment, and to workers' spouses and dependents who would lose such coverage due to death of the worker, divorce and Medicare eligibility; made private employer health plans primary to Medicare for active workers and their spouses who also have Medicare coverage; required that third-party payers reimburse for certain care rendered in government-run veterans and military hospitals; and established a task force to study long-term care insurance policies.

1986 Tax Reform Act of 1986 (P.L. 99-514) removed the federal tax exemption for Blue Cross-Blue Shield organizations engaged in providing commercial-type insurance, established uniform nondiscrimination rules for group health insurance plans and restored a partial, 25 percent tax deduction for health insurance premiums for self-employed individuals and their employees.

1986 Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509) made private employer health plans primary to Medicare for beneficiaries eligible by reason of permanent disability in cases where the disabled person is a covered dependent under a working spouse's health plan or if the disabled person returns to active employment and revised the formula for determining Medicare's Part A deductible.

1986 ADEA for 1967 was further amended to prohibit mandating retirement at any age; employer-provided benefits for older workers must be equal to those for younger workers.

1988 The Health Maintenance Organization Amendments of 1988 (P.L. 100-51) provided greatly enhanced flexibility to federally qualified HMOs for structuring their organizations and for calculating premiums. Employers also permitted to base their contributions to federally qualified HMOs on the projected claims experience of employees joining the HMO.

1988 The Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) represented the largest expansion in the Medicare program since its inception in 1965. Benefit changes included the elimination of all cost sharing for inpatient hospital care after the hospital deductible, a cap on out-of-pocket expenses for physicians' services of $1,370 and minor changes in skilled nursing, home health and respite care benefits. A phased-in outpatient drug benefit will be added to Medicare in 1991. Employers offering retiree health benefits to Medicare beneficiaries must rebate in cash or new benefits the actuarial value of the new catastrophic benefits for one year.

1988 Congress passed AIDS-related legislation containing funds for research, education, HIV testing and home health demonstration project.

1989 The Omnibus Budget Reconciliation Act of 1989, Title VI of H.R. 3299, contained a provision requiring states to extend Medicaid coverage to all pregnant women and children up to age 6 with family incomes up to 133 percent of federal poverty level ($13,380 for a family of three) by April 1, 1990. The act (P.L. 101-239) also included a three-part plan to reform the physician payment system under Medicare.

1989 The Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) was repealed.

GLOSSARY

Accident. An event or occurrence which is unforeseen and unintended.

Accidental Bodily Injury. Injury to the body as the result of an accident.

Accumulation Period. A specified period of time, such as 90 days, during which the insured person must incur eligible medical expenses at least equal to the deductible amount in order to establish a benefit period under a major medical expense or comprehensive medical expense policy.

Actuary. A person professionally trained to apply probability and statistics to the practical problems of insurance and related fields. He/she may specialize in life insurance, health insurance (long-term disability and medical), property and casualty insurance, pension work, government programs or a combination of these. His/her responsibilities include calculation of premiums, policy values, reserves and dividends, preparation of statistical studies and forecasting of financial results. Because of his/her broad training an actuary often has administrative and executive responsibilities.

Administrative Services Only (ASO) Plan. An arrangement under which an insurance carrier or an independent organization will, for a fee, handle the administration of claims, benefits and other administrative functions for a self-insured group.

Adverse Selection. The tendency of persons with poorer than average health expectations to apply for, or continue, insurance to a greater extent than do persons with average or better health expectations.

Age Limits. Stipulated minimum and maximum ages below and above which the company will not accept applications or may not renew policies.

Agent. An insurance company representative licensed by the state who solicits, negotiates or effects contracts of insurance, and provides service to the policyholder for the insurer.

Aggregate Indemnity. The maximum dollar amount that may be collected for any disability or period of disability under the policy.

AIDS. Acquired immune deficiency syndrome. A fatal, incurable disease caused by a virus that can damage the brain and destroy the body's ability to fight off illness. AIDS poses major problems for insurers, policyholders and the whole of society.

Allocated Benefits. Benefits for which the maximum amount payable for specific services is itemized in the contract.

Alternate Delivery Systems. Health services provided in other than an inpatient, acute-care hospital. Examples include skilled and intermediary nursing facilities, hospice programs and home health care. Alternate delivery systems are designed to provide needed services in a more cost-effective manner.

Ambulatory Care. Medical services that are provided on an outpatient (nonhospitalized) basis. Services may include diagnosis, treatment and rehabilitation.

Amendment. A formal document changing the provisions of an insurance policy signed jointly by the insurance company officer and the policy holder or his authorized representative.

Application. A signed statement of facts requested by the company on the basis of which the company decides whether or not to issue a policy. This then becomes part of the health insurance contract when the policy is issued.

Approval. (1) Word used in connection with the filing of policy and certificate forms and rates with the state insurance department. (2) A word used in connection with the underwriting process of an insurance company, consisting of the acceptance of the risk as set forth in the application as made or modified by the insurer. (3) Acceptance of an offer from an applicant or policyholder in the form of a contract for new insurance, reinstatement of a terminated policy, request for a policy loan, etc., by an officer of the company.

Assignment. The signed transfer of benefits of a policy by the owner of the policy to a third party.

Association Group. A group formed from members of a trade or a professional association for group insurance under one master health insurance contract.

Beneficiary. The person designated or provided for by the policy terms to receive the proceeds upon the death of the insured.

Benefits. The amount payable by the insurance company to a claimant, assignee or beneficiary under each coverage.

Binding Receipt. A receipt given for a premium payment accompanying the application for insurance. If the policy is approved, this binds the company to make the policy effective from the date of the receipt.

Blanket Contract. A contract of health insurance affording benefits, such as accidental death and dismemberment, for all of a class of persons not individually identified. It is used for such groups as athletic teams, campers, travel policy for employees, etc.

Blanket Medical Expense. A provision which entitles the insured person to collect up to a maximum established in the policy for all hospital and medical expenses incurred, without any limitations on individual types of medical expenses.

Blue Cross. An independent, nonprofit membership corporation providing protection on a service basis against the cost of hospital care in a limited geographical area.

Blue Shield. An independent, nonprofit membership corporation providing protection on a service basis against the cost of surgical and medical care in a limited geographical area.

Broker. A sales and service representative who handles insurance for clients, generally selling insurance of various kinds and for several companies.

Business Insurance. A policy which primarily provides coverage of benefits to a business as contrasted to an individual. It is issued to indemnify a business for the loss of services of a key employee or a partner who becomes disabled.

Capitation. A method of payment for health services in which a physician or hospital is paid a fixed, per capita amount for each person served regardless of the actual number of services provided to each person.

Certificate of Insurance. A statement of coverage issued to an individual insured under a group insurance contract, outlining the insurance benefits and principal provisions applicable to the member.

Claim. A demand to the insurer for the payment of benefits under the insurance contract.

Coinsurance. A policy provision frequently found in major medical insurance, by which both the insured person and the insurer share the covered losses under a policy in a specified ratio, i.e., 80 percent by the insurer and 20 percent by the insured.

Comprehensive Major Medical Insurance. A policy designed to give the protection offered by both a basic and a major medical health insurance policy. It is characterized by a low deductible amount, a coinsurance feature and high maximum benefits.

Consideration. One of the elements for a binding contract. Consideration is acceptance by the insurance company of the payment of the premium and the statement made by the prospective policyholder in the application.

Contributory. A group insurance plan issued to an employer under which both the employer and employee contribute to the cost of the plan. Seventy-five percent of the eligible employees must be insured. (See Noncontributory.)

Conversion Privilege. A privilege granted in an insurance policy to convert to a different plan of insurance without providing evidence of insurability. The privilege granted by a group policy is to convert to an individual policy upon termination of group coverage.

Coordination of Benefits (COB). The specific term used to designate the antiduplication provision designed by the group health insurance industry through the Health Insurance Association of America (HIAA) to limit benefits for multiple group health insurance in a particular case to 100 percent of the expenses covered and to designate the order in which the multiple carriers are to pay benefits.

Cost Containment. The control or reduction of inefficiencies in the consumption, allocation or production of health care services that contribute to higher than necessary costs.

Covered Expenses. Hospital, medical and miscellaneous health care expenses incurred by the insured that entitle him/her to a payment of benefits under a health insurance policy. Found most often in connection with major medical plans, the term defines, by either description, reasonableness or necessity to specify the type and amount of expense which will be considered in the calculation of benefits.

Deductible. The amount of covered charges incurred by the protected person which must be assumed or paid by the insured before benefits by the insurance company become payable. A deductible is most commonly used in major medical policies; however, it may also be incorporated in base plan policies.

Diagnosis-Related Groups (DRGs). System that reimburses health care providers fixed amounts for all care given in connection with standard diagnostic categories.

Disability. Physical or mental handicap resulting from sickness or injury. It may be partial or total. (See Partial Disability; Total Disability.)

Disability Income Insurance. A form of health insurance that provides periodic payments to replace income when an insured person is unable to work as a result of illness, injury or disease.

Dismemberment. Loss of body members (limbs), or use thereof, or loss of sight due to injury.

Disposable Personal Income. The personal income less personal tax and nontax payments. It is the income available to people for spending and saving.

Double Indemnity. A policy provision usually associated with death, which doubles payment of a designated benefit when certain kinds of accidents occur.

Dread Disease Insurance. Insurance providing an unallocated benefit, subject to a maximum amount, for expenses incurred in connection with the treatment of specified diseases, such as cancer, poliomyelitis, encephalitis and spinal meningitis.

Duplication of Benefits. Overlapping or identical coverage of the same insured under two or more health plans, usually the result of contracts of different insurance companies, service organizations or prepayment plans; also known as multiple coverage.

Earned Premium. That portion of a policy's premium payment for which the protection of the policy has already been given. For example, an insurance company is considered to have earned 75 percent of an annual premium after a period of nine months of an annual term has elapsed.

Effective Date. The date on which the insurance under a policy begins.

Eligibility Date. The date on which an individual member of a specified group becomes eligible to apply for insurance under the (group life or health) insurance plan.

Eligible Employees. Those members of a group who have met the eligibility requirements under a group life or health insurance plan.

Eligibility Period. A specified length of time, frequently 31 days, following the eligibility date during which an individual member of a particular group will remain eligible to apply for insurance under a group life or health insurance policy without evidence of insurability.

Elimination Period. A period of time between the period of disability and the start of disability income insurance benefits, during which no benefits are payable. (See Waiting Period.)

Enrollment Card. A document signed by an employee as notice of his/her desire to participate in the benefits of a group insurance plan.

Evidence of Insurability. Any statement of proof of a person's physical condition and/or other factual information affecting his/her acceptance for insurance.

Exclusions. Specific conditions or circumstances listed in the policy for which the policy will not provide benefit payments.

Exclusive Provider Organization (EPO). People who belong to an EPO must receive their care from affiliated providers; services rendered by unaffiliated providers are not reimbursed.

Experience. A term used to describe the relationship, usually expressed as a percent or ratio, of premium to claims for a plan, coverage or benefits for a stated time period.

Experience Rating. The process of determining the premium rate for a group risk, wholly or partially on the basis of that group's experience.

Experience Refund. A provision in most group policies for the return of premium to the policyholder because of lower than anticipated claims.

Family Expense Policy. A policy which insures both the policyholder and his/her immediate dependents (usually spouse and children).

Flat Schedule. A type of schedule in group insurance under which everyone is insured for the same benefits regardless of salary, position or other circumstances.

Franchise Insurance. A form of insurance in which individual policies are issued to the employees of a common employer or the members of an association under an arrangement by which the employer or association agrees to collect the premiums and remit them to the insurer.

Fraternal Insurance. A cooperative type of insurance provided by social organizations for their members.

Geographic Divisions (in the United States)
NORTHEAST
New England: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Middle Atlantic: New Jersey, New York, Pennsylvania
MIDWEST
East North Central: Illinois, Indiana, Michigan, Ohio, Wisconsin
West North Central: Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota
SOUTH
South Atlantic: Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia
East South Central: Alabama, Kentucky, Mississippi, Tennessee
West South Central: Arkansas, Louisiana, Oklahoma, Texas
WEST
Mountain: Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming
Pacific: Alaska, California, Hawaii, Oregon, Washington.

Grace Period. A specified period after a premium payment is due, in which the policyholder may make such payment, and during which the protection of the policy continues.

Group Contract. A contract of insurance made with an employer or other entity that covers a group of persons identified as individuals by reference to their relationship to the entity.

Guaranteed Renewable Contract. A contract that the insured person or entity has the right to continue in force by the timely payment of premiums for a substantial period of time, during which period the insurer has no right to make unilaterally any change in any provision of the contract, while the contract is in force, other than a change in the premium rate for classes of policyholders.

Health Insurance. Protection which provides payment of benefits for covered sickness or injury. Included under this heading are various types of insurance such as accident insurance, disability income insurance, medical expense insurance and accidental death and dismemberment insurance.

Health Maintenance Organizaton (HMO). An organization that provides a wide range of comprehensive health care services for a specified group at a fixed periodic payment. The HMO can be sponsored by the government, medical schools, hospitals, employers, labor unions, consumer groups, insurance companies and hospital-medical plans.

Hospice. Health care facility providing medical care and support services such as counseling to terminally ill persons.

Hospital Expense Insurance. Health insurance protection against the cost of hospital care resulting from the illness or injury of the insured person.

Hospital Indemnity. A form of health insurance which provides a stipulated daily, weekly or monthly indemnity during hospital confinement. The indemnity is payable on an unallocated basis without regard to the actual expense of hospital confinement.

Hospital Medical Insurance. A term used to indicate protection which provides benefits for the cost of any or all of the numerous health care services normally covered under various health care plans.

Incontestable Clause. An optional clause which may be used in noncancelable or guaranteed renewable health insurance contracts providing that the insurer may not contest the validity of the contract after it has been in force for two (sometimes three) years.

Incurred Claims. Incurred claims equal the claims paid during the policy year plus the claim reserves as of the end of the policy year, minus the corresponding reserves as of the beginning of the policy year. The difference between the year end and beginning of the year claim reserves is called the increase in reserves and may be added directly to the paid claims to produce the incurred claims.

Indemnity. Benefits paid in a predetermined amount in the event of a covered loss.

Individual Insurance. Policies which provide protection to the policyholder and/or his/her family. Sometimes called Personal Insurance as distinct from group and blanket insurance.

Injury Independent of All Other Means. An injury resulting from an accident, provided that the accident was not caused by an illness.

Insurable Risk. The conditions that make a risk insurable are (a) the peril insured against must produce a definite loss not under the control of the insured, (b) there must be a large number of homogeneous exposures subject to the same perils, (c) the loss must be calculable and the cost of insuring it must be economically feasible, (d) the peril must be unlikely to affect all insureds simultaneously and (e) the loss produced by a risk must be definite and have a potential to be financially serious.

Insurance. Protection by written contract against the financial hazards (in whole or in part) of the happenings of specified fortuitous events.

Insurance Company. Any corporation primarily engaged in the business of furnishing insurance protection to the public.

Insuring Clause. The clause which sets forth the type of loss being covered by the policy and the parties to the insurance contract.

Integration. A coordination of the disability income insurance benefit with other disability income benefits, such as Social Security, through a specific formula to insure reasonable income replacement.

Key-man or Key-person Health Insurance. An individual or group insurance policy designed to protect a firm against the loss of income resulting from disability of a key employee.

Lapse. Termination of a policy upon the policyholder's failure to pay the premium within the time required.

Legal Reserve. The minimum reserve which a company must keep to meet future claims and obligations as they are calculated under the state insurance code.

Level Premium. A premium which remains unchanged throughout the life of a policy.

Lifetime Disability Benefit. A benefit to help replace income lost by an insured person as long as he/she is totally disabled, even for a lifetime.

Limited Policy. A contract which covers only certain specified diseases or accidents.

Long-Term Care. The continuum of broad-ranged maintenance and health services to the chronically ill, disabled or retarded. Services may be provided on an inpatient (rehabilitation facility, nursing home, mental hospital), outpatient or at-home basis.

Long-Term Disability Income Insurance. Insurance issued to an employer (group) or individual to provide a reasonable replacement of a portion of an employee's earned income lost through serious and prolonged illness or injury during the normal work career. (See also Integration.)

Major Medical Insurance. Health insurance to finance the expense of major illness and injury. Characterized by large benefit maximums ranging up to $250,000 or no limit, the insurance, above an initial deductible, reimburses the major part of all charges for hospital, doctor, private nurses, medical appliances, prescribed out-of-hospital treatment, drugs and medicines. The insured person as coinsurer pays the remainder.

Managed Care. Health care systems that integrate the financing and delivery of appropriate health care services to covered individuals by arrangements with selected providers to furnish a comprehensive set of health care services, explicit standards for selection of health care providers, formal programs for ongoing quality assurance and utilization review and significant financial incentives for members to use providers and procedures associated with the plan.

Manual Rate. The premium rate developed for a group insurance coverage from the company's standard rate tables normally referred to as its rate manual or underwriting manual.

Medicaid. State programs of public assistance to persons regardless of age whose income and resources are insufficient to pay for health care. Title XIX of the federal Social Security Act provides matching federal funds for financing state Medicaid programs, effective January 1, 1966.

Medicare. The hospital insurance system and the supplementary medical insurance for the aged created by the 1965 amendments to the Social Security Act and operated under the provisions of the Act.

Medigap. A term sometimes applied to private insurance products that supplement Medicare insurance benefits.

Minimum Group. The least number of employees permitted under a state law to effect a group for insurance purposes; the purpose is to maintain some sort of proper division between individual policy insurance and the group forms.

Minimum Premium Plan (MPP). An arrangement under which an insurance carrier will, for a fee, handle the administration of claims and insure against large claims for a self-insured group.

Miscellaneous Expenses. Expenses in connection with hospital insurance, hospital charges other than room and board, such as X-rays, drugs, laboratory fees and other ancillary charges. (Sometimes referred to as Ancillary Charges.)

Morbidity. The incidence and severity of sicknesses and accidents in a well-defined class or classes of persons.

Multiple Employer Trust (MET). A legal trust established by a plan sponsor that brings together a number of small, unrelated employers for the purpose of providing group medical coverage on an insured or self-funded basis.

National Association of Insurance Commissioners (NAIC). The association of insurance commissioners of various states formed to promote national uniformity in the regulation of insurance.

Noncancelable Guaranteed Renewable Policy. An individual policy which the insured person has the right to continue in force until a specified age, such as to age 65, by the timely payment of premiums. During this period, the insurer has no right to unilaterally make any changes in any provision of the policy while it is in force.

Noncontributory. A term applied to employee benefit plans under which the employer bears the full cost of the benefits for the employees. One hundred percent of the eligible employees must be insured.

Nondisabling Injury. An injury which may require medical care, but does not result in loss of working time or income.

Nonoccupational Policy. Contract which insures a person against off-the-job accident or sickness. It does not cover disability resulting from injury or sickness covered by Worker's Compensation. Group accident and sickness policies are frequently nonoccupational.

Nonparticipating Insurance. Plan of insurance under which the policyholder is not entitled to share in the dividend distribution of the company.

Nonprofit Insurers. Persons organized under special state laws to provide hospital, medical or dental insurance on a nonprofit basis. The laws exempt them from certain types of taxes.

Occupational Hazards. Occupations which expose the insured to greater than normal physical dangers by the very nature of the work in which the insured is engaged, and the varying periods of absence from the occupation, due to the disability, that can be expected.

Optionally Renewable Contract. A contract of health insurance in which the insurer reserves the right to terminate the coverage at any anniversary or, in some cases, at any premium due date, but does not have the right to terminate coverage between such dates.

Overhead Insurance. A type of short-term disability income contract that reimburses the insured person for specified, fixed monthly expenses, normal and customary in the operation and conduct of his/her business or office.

Partial Disability. The result of an illness or injury which prevents an insured from performing one or more of the functions of his/her regular job.

Participating Insurance. Insurance issued by an insurance company providing participation in dividend distribution.

Physician's Expense Insurance. Coverage which provides benefits toward the cost of such services as doctor's fees for nonsurgical care in the hospital, at home or in a physician's office, and X-rays or laboratory tests performed outside the hospital. (Also called Regular Medical Expense Insurance.)

Point-of-Service Plans. Often known as open-ended HMOs or PPOs, these plans permit insureds to choose providers outside the plan yet are designed to encourage the use of network providers.

Policy. The legal document issued by the company to the policyholder, which outlines the conditions and terms of the insurance; also called the policy contract or the contract.

Policy Term. That period for which an insurance policy provides coverage.

Preadmission Certification. Process in which a health care professional evaluates an attending physician's request for a patient's admission to a hospital by using established medical criteria.

Preexisting Condition. A physical and/or mental condition of an insured which first manifested itself prior to the issuance of his/her policy or which existed prior to issuance and for which treatment was received.

Preferred Provider Organization (PPO). An arrangement whereby a third-party payer contracts with a group of medical care providers who furnish services at lower than usual fees in return for prompt payment and a certain volume of patients.

Premium. The periodic payment required to keep a policy in force.

Prepaid Group Practice Plan. A plan under which specified health services are rendered by participating physicians to an enrolled group of persons, with a fixed periodic payment in advance made by or on behalf of each person or family. If a health insurance carrier is involved, a contract to pay in advance for the full range of health services to which the insured is entitled under the terms of the health insurance contract. Such a plan is one form of Health Maintenance Organization (HMO).

Principal Sum. The amount payable in one sum in the event of accidental death and in some cases accidental dismemberment.

Professional Review Organization (PRO). An organization in which practicing physicians assume responsibility for reviewing the propriety and quality of health care services provided under Medicare and Medicaid.

Proration. The adjustment of benefits paid because of a mistake in the amount of the premiums paid or the existence of other insurance covering the same accident or disability.

Prospective Payment. An advancement of payment for health care charges that are likely to occur.

Qualified Impairment Insurance. A form of substandard or special class insurance, which restricts benefits for the insured person's particular condition.

Reasonable and Customary Charge. A charge for health care, which is consistent with the going rate or charge in a certain geographical area for identical or similar services.

Recurring Clause. A provision in some health insurance policies, which specifies a period of time during which the recurrence of a condition is considered a continuation of a prior period of disability or hospital confinement.

Rehabilitation. (1) Restoration of a totally disabled person to a meaningful occupation, (2) a provision in some long-term disability policies that provides for continuation of benefits or other financial assistance while a totally disabled insured is retraining or attempting to resume productive employment.

Reinstatement. The resumption of coverage under a policy which has lapsed.

Reinsurance. The acceptance by one or more insurers, called reinsurers, of a portion of the risk underwritten by another insurer who has contracted for the entire coverage.

Renewal. Continuance of coverage under a policy beyond its original term by the insurer's acceptance of the premium for a new policy term.

Residual Disability Benefits. A provision in an insurance policy that provides benefits in proportion to a reduction of earnings as a result of disability, as opposed to the inability to work full-time.

Rider. A document which amends the policy or certificate. It may increase or decrease benefits, waive the condition of coverage or in any other way amend the original contract.

Risk. Any chance of loss.

Self-Administration. The procedure where an employer maintains all records regarding the employees covered under a group insurance plan.

Self-Insurance. A program for providing group insurance with benefits financed entirely through the internal means of the policyholder, in place of purchasing coverage from commercial carriers.

Senior Citizen Policies. Contracts insuring persons 65 years of age or over. In most cases these policies supplement the coverage afforded by the government under the Medicare program.

Short-Term Disability Income Insurance. The provision to pay benefits to a covered disabled person as long as he/she remains disabled up to a specified period not exceeding two years.

Social Security Freeze. A long-term disability policy provision which establishes that the offset from benefits paid by Social Security will not be changed regardless of subsequent changes in the Social Security law.

Special Risk Insurance. Coverage for risks or hazards of a special or unusual nature.

Standard Insurance. Insurance written on the basis of regular morbidity underwriting assumption used by an insurance company and issued at normal rates.

Standard Provision. Those contract provisions generally required by state statutes until superseded by the uniform policy provision.

Standard Risk. A person who, according to a company's underwriting standards, is entitled to insurance protection without extra rating or special restrictions.

State Disability Plan. A plan for accident and sickness, or disability insurance required by state legislation of those employers doing business in that particular state.

State Insurance Department. A department of a state government whose duty is to regulate the business of insurance and give the public information on insurance.

Substandard Insurance. Insurance issued with an extra premium or special restriction to those persons who do not qualify for insurance at standard rates.

Substandard Risk. An individual, who, because of health history or physical limitations, does not measure up to the qualification of a standard risk.

Surgical Expense Insurance. Health insurance policies, which provide benefits toward the physician's or surgeon's operating fees. Benefits may consist of scheduled amounts for each surgical procedure.

Surgical Schedule. A list of cash allowances attached to the policy, which are payable for various types of surgery, with a maximum amount based upon the severity of the operation.

Third-Party Administration. Administration of a group insurance plan by some person or firm other than the insurer or the policyholder.

Time Limit. The period of time during which a notice of claim or proof of loss must be filed.

Total Disability. An illness or injury which prevents an insured person from continuously performing every duty pertaining to his/her occupation or engaging in any other type of work. (This wording varies among insurance companies.)

Travel Accident Policy. A limited contract covering only accidents while an insured person is traveling, usually on a commercial carrier.

Unallocated Benefit. A policy provision providing reimbursement up to a maximum amount for the cost of all extra miscellaneous hospital services, but not specifying how much will be paid for each type of service.

Underwriter. The term as generally used applies to either (a) a company which receives the premiums and accepts responsibility for the fulfillment of the policy contract; (b) the company employee who decides whether or not the company should assume a particular risk; (c) the agent who sells the policy.

Underwriting. The process by which an insurer determines whether or not and on what basis an application for insurance will be accepted.

Unearned Premium. That portion of the paid premium applying to the unexpired portion of the policy term; or that portion of the paid premium for which protection has not been received.

Uninsurable Risk. One not acceptable for insurance due to excessive risk.

Waiting Period. The length of time an employee must wait from his/her date of employment or application for coverage, to the date his/her insurance is effective.

Waiver. An agreement attached to a policy which exempts from coverage certain disabilities or injuries which are normally covered by the policy.

Waiver of Premium. A provision included in some policies which exempts the policyholder from paying the premiums while an insured is totally disabled, during the life of the contract.

Worker's Compensation. Insurance against liability imposed on certain employers to pay benefits and furnish care to employees injured, and to pay benefits to dependents of employees killed in the course of or arising out of their employment.

Written Premiums. The entire amount of premiums due in a year for all policies issued by an insurance company.

INDEX

Absenteeism, see Disability days
Accident and health insurance, see Health insurance
Accident and sickness insurance, see Health insurance
Accidents, cost of, 54,74
Administrative services only (ASO) plans, 4,10,111
AIDS, 90,96,111

Baby, cost of having, 53,69
Bed disability days, see Disability days
Beds, hospital, see Hospitals
Blue Cross-
  Blue Shield, 23,26,28,30,36

CHAMPUS, 38
Claims payments, 6,7,14,26,27,28
Community hospital statistics, see Hospitals
Consumer price index, 50,63
Coverage
  health insurance,9
    by race, 22,24,25
    by age, 22,24,25
    population, percent of, 7,22,23
    private, 7,22,23
    public, 7
    Blue Cross-Blue Shield, 23
    employer-related, 7
    Medicaid, recipients, 41,42
    Medicare, enrolled, 40,42
    other plans, 23

Dental expense insurance
  claims payments, 27
  premiums, 29
Dentists
  services, 11,56,61,63
  number of, 85
Disability, probability of, 90
Disability, 11,87
  by age, 91
  by geographic region, 91
  by income, 91
  by industry, 93
  by metropolitan status, 91
  by sex, 91,92
  by type of condition, 88,89,91,92
  disability days, 87,88,91
  lost workdays, 94
Disability income insurance claims
  payments (insurance companies), loss of income, 11,27,28
  premiums (insurance companies), 28,29,30
Disability Insurance Program, Social Security, 89
Disposable personal income, 62,114
Drugs
  consumer price index, 63
  expenditures for, 7,56

Expenditures for medical care, see Personal consumption expenditures and Personal health care expenditures
Eyeglasses & appliances, see Vision products

Federal programs, 35,36,37,38

Gross national product, 49,50,58
Group health insurance (insurance companies), 12
  claims payments, 27
  premiums, 29

Health insurance, claims payments, 7,14
  coverage, 9
  history, 1,2,3,4,5,6
  (see Historical Insurance Facts), 103-109
  premiums, 15,28,29,30
Health maintenance organizations (HMOs), 19
  enrollment, 31,32
  number, 31,32
  premiums, 17
Health services
  utilization, 75,76,77,78,79,80
Hospital
  premiums, see Hospital-medical insurance
Hospital-medical insurance (insurance companies), 10
  claims, 27,28
  premiums, 29,30
Hospital care expenditures, 51
Hospitals, community, 51
  admissions, 64,77,86
  average length of stay, 64,78,84
  beds, 64,77,86
  discharges, 78,80
  expenses, 51
    average cost per patient day, 64
    average cost per patient stay, 64
    occupancy, 77,86
  psychiatric, 51
  special facilities, 83
  room and board rates
    semiprivate room charges, 51,66

Indian health services, 38
Individual health insurance (insurance companies)
  claims payments, 28
  premiums, 30
Insurance companies
  claims payments, 26,27,28
  coverage, 23
  fiscal intermediaries for Medicare, 36
  premiums, 28,29,30
Insured, see Coverage
International health care, 54,55
  coverage, 54
  as percent of GDP, 54,55

Life expectancy, 90,96
Loss-of-income insurance, see Disability income insurance
Long-term care, 12

Major medical expense insurance
  coverage, 11
Managed care
  current trends, 4,5
  definition of, 19
  enrollment, 31,32
  evolution, 18
  history of managed care, 19
  types of managed care, 19
Medicaid, 3,41,42
Medical care expenditures, see Personal consumption expenditures and Personal health care expenditures
Medicare, 3,40,42
Mental health, 70
  costs, 53,71
  visits, 53,71
Military personnel and dependents, 37
Morbidity, 89
  causes of death, 97,98

Mortality, 89
  trends in death rates, 99

National health expenditures, 7,47,48,49,56,57,58
Nursing home care, 9,56

Organ transplants, 77,86
Osteopaths
  number of, 85
Ownership of health insurance, see Coverage

Payment of claims, see Claims payments
Personal consumption expenditures, 60,61,62
Personal health care expenditures, 56,59
Physicians
  fees, 52,67,68
  numbers of, 85
  visits to, 68,76,82
    by geographic region, 52,82
    per physician per week, 82
Physicians' services, expenditures for, 7,56,60,61
Preferred provider organizations (PPOs), 4,20,34
Premiums
  individual health insurance, 15,16,17,18,28
  (insurance companies)
    Blue Cross-Blue Shield, 1,5,7
    insurance companies, 1,5,7
    by type of plan, 16
    paid by employers, 18
Prescriptions and drugs, see Drugs

Ratio to disposable personal income, 62
Restricted activity days, see Disability days

Self-insurance, 12
Semiprivate room charges, 66
Social Security, 95
  Disability Insurance Program, 95
  Medicaid, 3,41,42
  Medicare, 3,41,42
State and local health programs, 38,44
Subscription income (Blue Cross-Blue Shield), see Premiums—Blue Cross-Blue Shield
Surgical charges, 52
Surgical procedures, 52,67
  inpatient, 73
  outpatient, 73

Trends in morbidity, 98
Type of insurance, see Dental expense insurance, Disability income insurance, Hospital-medical expense insurance, Major medical expense insurance

Underwriting results, 30
Uninsured population, 13,14

Veterans' medical care, 38, see CHAMPUS and Federal programs
Vision products, 7,56

Work-loss days, see Disability days
Worker's compensation, 43